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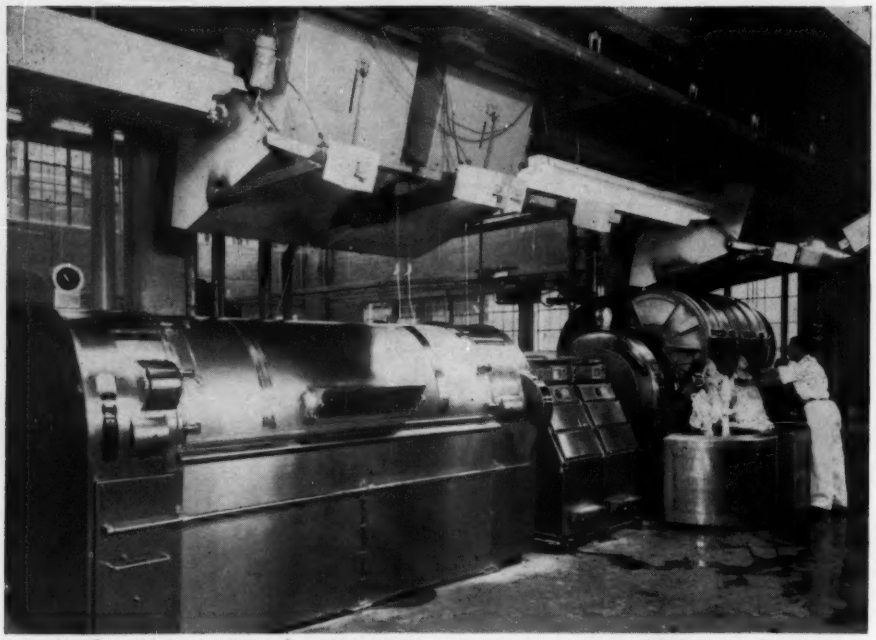

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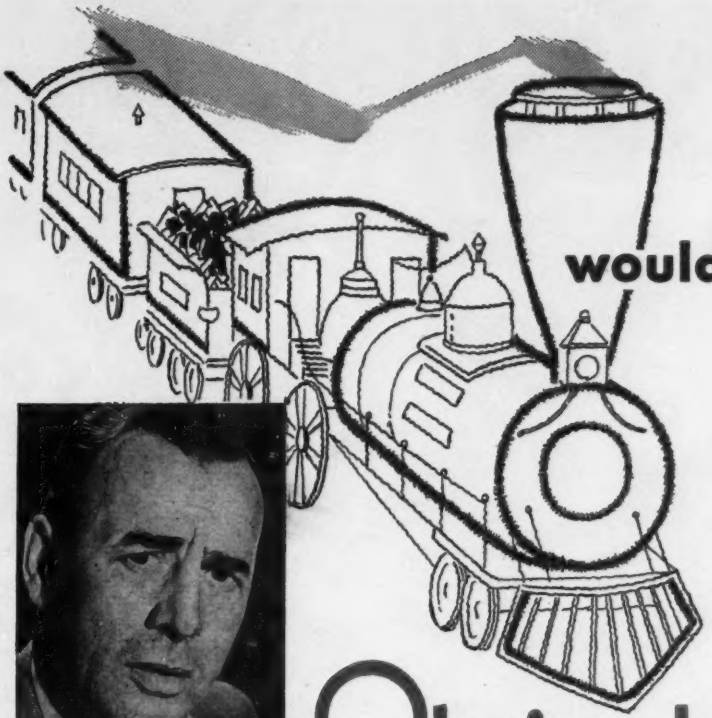

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Contents

Vol. 32 **SEPTEMBER, 1955** No. 9

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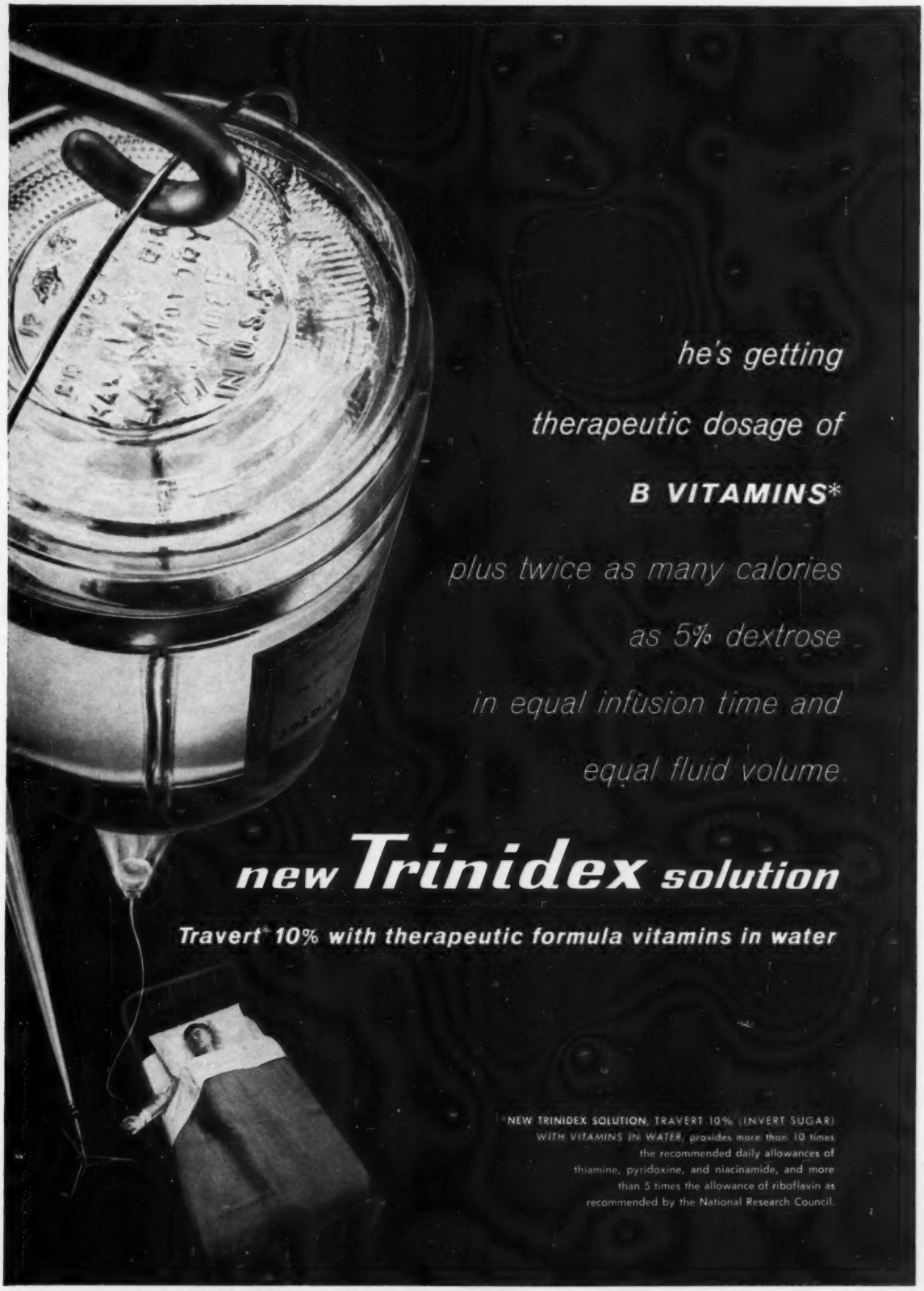

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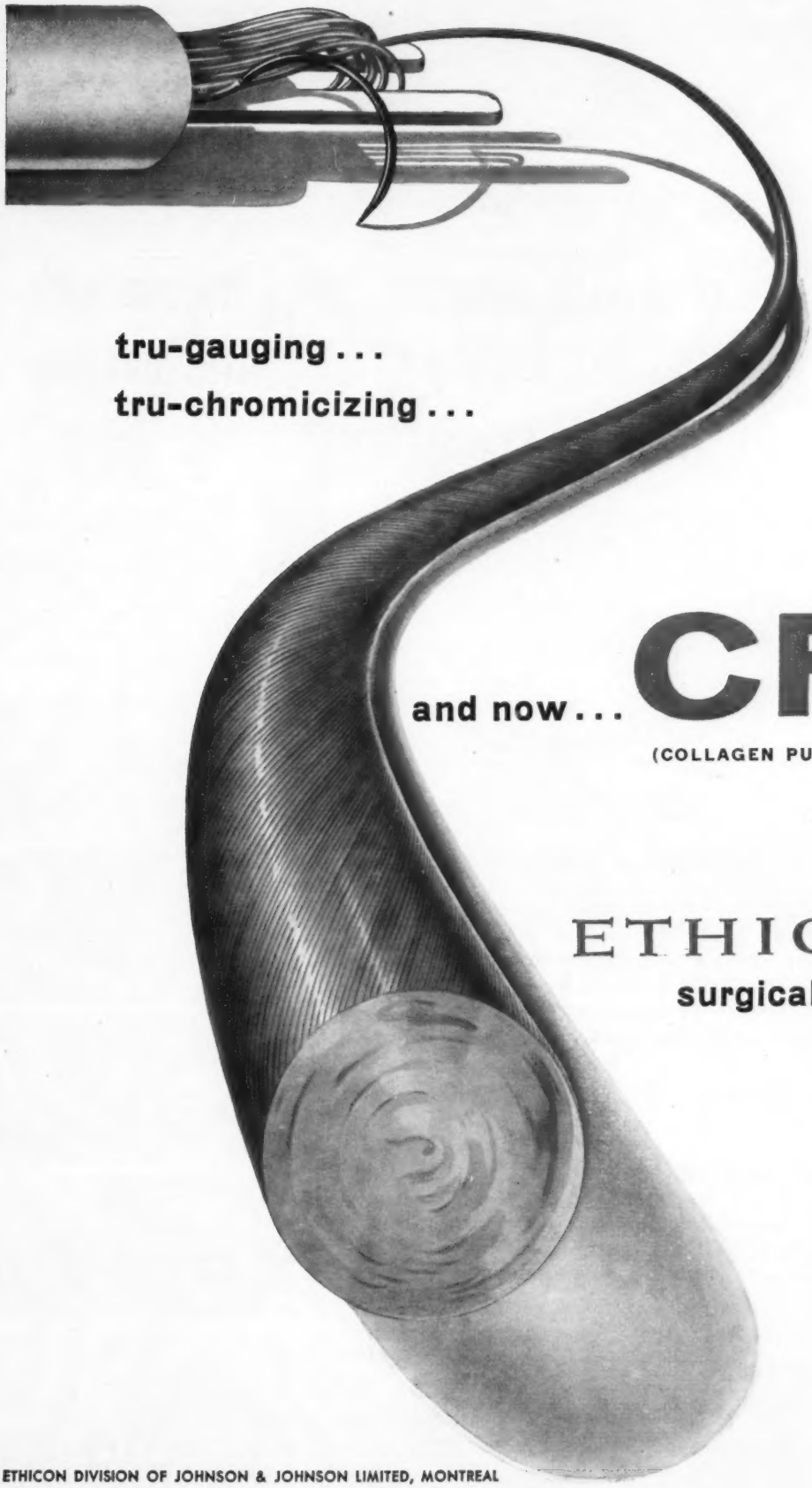

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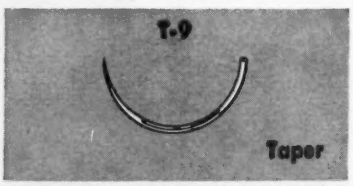

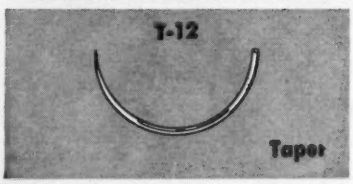

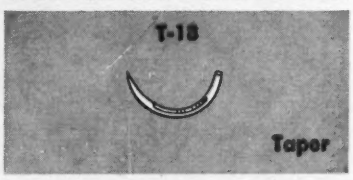

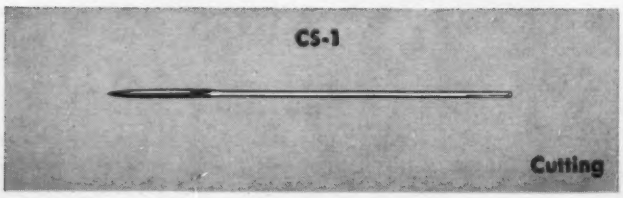

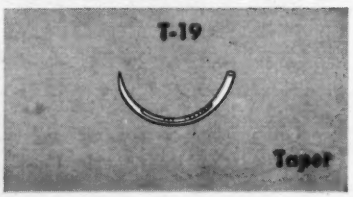

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1561	C, Med. Chromic	27"	T-18	000 to 1
1563	C, Med. Chromic	27"	T-19	00 to 1
1547	C, Med. Chromic	27"	C-9	000 to 2
687	C, Med. Chromic	27"	C-10	000 to 2
689	D, Extra Chromic	27"	C-10	00
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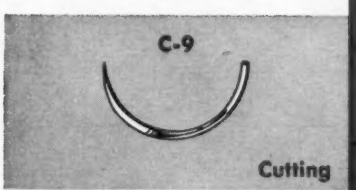

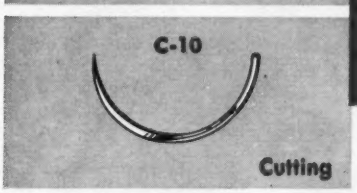

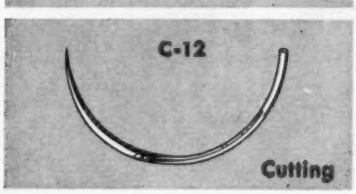

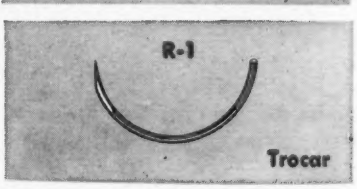

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◄ Notes About People ►

About the first vice-president of the Canadian Hospital Association

(This is the third of a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57—Edit.)

Dr. D. F. W. Porter, first vice-president of the Canadian Hospital Association, has had an interesting and varied career in medicine and hospital administration. A native of New Brunswick, he attended elementary and high schools in Fredericton and, following a pre-medical course of two years at the University of New Brunswick, graduated in medicine from McGill University in 1925. After a period in general practice at Minto, N.B., he continued his studies at the St. Louis Children's Hospital, St. Louis, Mo.; and then practised for some ten years as a specialist in paediatrics at Saint John, N.B.

During World War II, Dr. Porter served in the army medical services of Canada, first as regimental medical officer, then as senior medical officer of the third Canadian infantry brigade, senior medical officer of the Canadian anti-aircraft group, officer commanding No. 2 Canadian casualty clearing station, later as assistant director of medical services, Canadian army in the field, and as commanding officer of No. 24 Canadian General Hospital (1500 beds). After the war Dr. Porter was director of hospital services for New Brunswick for a period of two years; and in 1949 he accepted the post of executive director of the Moncton Hospital. During his superintendency, one of his major contributions was active participation in the planning of the new hospital containing 210 beds, which was officially opened in July, 1953.

Dr. D. F. W. Porter

The Mother Provincial of the Religious Hospitallers of St. Joseph at Vallée Lourdes, N.B., announced recently that, effective September 1st, 1955, the Sisterhood has appointed Dr. Porter as consulting medical director and administrative consultant to the individual hospitals of that Order. He will also act in a similar capacity for the Mother Provincial and her council. The Religious Hospitallers operate active treatment hospitals at Sorel, P.Q., and in New Brunswick at Edmunston, Perth, St. Quentin, Campbellton, Lameque, Tracadie, and Bathurst; and also a long-term hospital at St. Basile and tuberculosis sanatoria at St. Basile and Vallée Lourdes. The changing pattern of hospital care and the more rigid standards necessary to meet the requirements of the hospital accreditation program have for some time past indicated to the order the need for this new type of consulting service which is unique in its plan. The order is anxious to work in the closest co-operation with the medical and nursing professions, to continue their very active participation in hospital associations at national and provincial levels, and to ensure that the individual hospitals of their group are designed and administered along the most efficient lines possible. In the initial phases of his new work, Dr. Porter will make his headquarters at Bathurst, N.B.

Dr. Porter has been a director of the Canadian Hospital Association since 1951, chairman of the New Brunswick section and a past president of the Maritime Hospital Association, and is well known in the Maritimes as a consultant in hospital design and equipment. His many friends throughout Canada wish Dr. Porter every success in his new work.

* * *

Dr. Austin M. Clarke Takes Moncton Post

Dr. Austin M. Clarke has been appointed executive director of the Moncton Hospital, Moncton, N.B., and succeeds Dr. D. F. W. Porter who resigned recently. Dr. Clarke has held the post of assistant chief medical officer and director of health planning services of the New Brunswick Department of Health and Social Services since 1948. He has been in the hospital and health fields for many years and assumes his new duties this month.

* * *

Ronald J. C. McQueen Joins Headquarters Staff

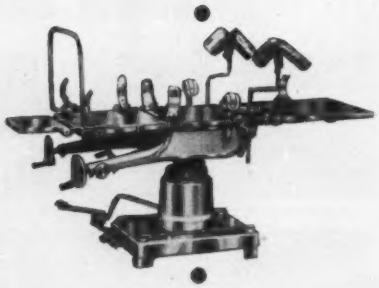
Dr. J. Gilbert Turner, President of the Canadian Hospital Association, on behalf of the Board of Directors has announced the appointment of Ronald J. C. McQueen to the staff of the association. He succeeds Donald M. MacIntyre who resigned in June to accept a hospital position in British Columbia.

Ronald J. C. McQueen

A native of Durham, Ontario, Mr. McQueen was graduated in Arts from the University of Toronto in 1948. Thereafter he was employed by the Communications Branch of the National Research Council in Ottawa. He returned to Toronto in September, 1953, and enrolled in the diploma

(Continued on page 16)

AT THE HEAD OF THE SURGICAL TEAM



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Notes About People

(Continued from page 12)

course in hospital administration at the School of Hygiene, University of Toronto. Mr. McQueen took his administrative residency at the Peterborough Civic Hospital, under the preceptorship of John Hornal.

Mr. McQueen's duties with the association will include the direction of the extension course in hospital organization and management and the extension course for the training of medical record librarians. He commenced his new duties this month.

* * *

Appointed to Ottawa General

Effective September 1, 1955, Dr. J. Paul Laplante has been appointed medical director of the Ottawa General Hospital on a full-time basis. Since 1952 Dr. Laplante has been assisting in the medical administration of the hospital in an advisory capacity.

After graduating in Arts from Loyola College, Montreal, Dr. Laplante attended McGill University where he graduated in medicine. Following rotating internships at the Montreal General Hospital and the Children's Memorial Hospital, he was night admitting officer of the Montreal General Hospital and, in 1932, was appointed medical superintendent of Hôpital St-Luc in that city. From 1935 to 1940 he practised medicine in Granby, Que.

During World War II, Dr. Laplante served with the RCAMC as registrar of No. 1 Canadian General Hospital, assistant to the director of Medical Services Overseas, officer commanding No. 5 Canadian Casualty Clearing Station, officer commanding No. 13 Canadian General Hospital, and officer commanding Montreal Military Hospital in 1945. He rose to the rank of colonel. In 1946 Dr. Laplante was appointed superintendent of Ste-Anne's Hospital at Ste Anne de Bellevue, Que. In 1951 he was appointed a commissioner of the Canadian Pension Commission, a post he will now relinquish.

Since 1954 Dr. Laplante has been a surveyor of the American Hospital Association for the Joint Commission on Accreditation of Hospitals. Dr. Laplante is active in many medical and hospital associations and is a nominee of the American College of Hospital Administrators. He brings to his new position many years of experience in hospital administration.

* * *

Alfred T. Story Named Administrator

Alfred T. Story is the new administrator at the Guelph General Hospital, succeeding W. E. Cox. He formerly held the post of office manager and accountant at the Owen Sound General and Marine Hospital, where he worked for the past six years. Mr. Story is also the vice-chairman of the Accounting Section Committee of the Ontario Hospital Association, and has recently completed the Canadian Hospital Association's extension course in hospital organization and management.

* * *

Sister M. Louise Now in Comox, B.C.

Sister M. Louise, formerly superintendent of St. Joseph's Hospital, Toronto, has left Ontario to undertake new duties at St. Joseph's Hospital, Comox, B.C.

Sister Louise is well known in hos-

(Continued on page 22)

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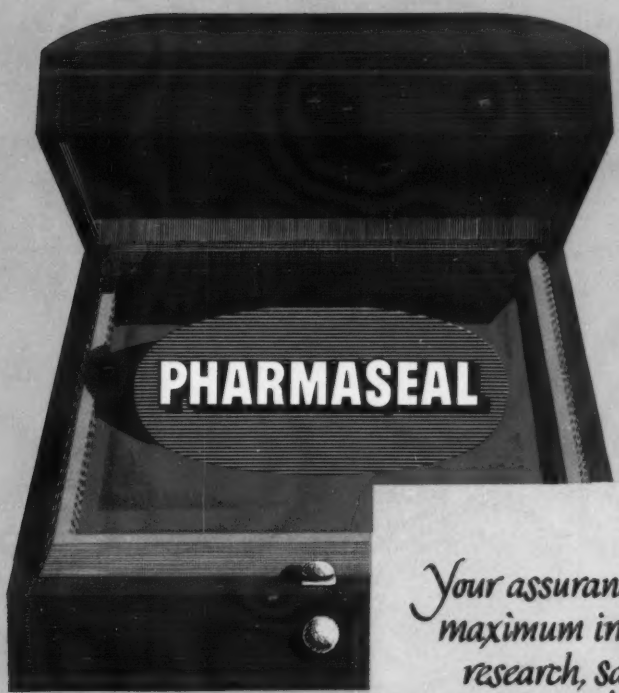

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Notes About People

(Continued from page 16)

pital circles throughout Canada and has been active in such organizations as the Toronto Hospital Council, the Ontario Conference of the Catholic Hospital Association, and the Ontario Hospital Association. At the time of her departure, she was a vice-president of the latter association.

Her duties at St. Joseph's Hospital, Toronto, are being assumed by Sister M. Estelle, formerly assistant superintendent of St. Michael's Hospital, Toronto.

* * * *

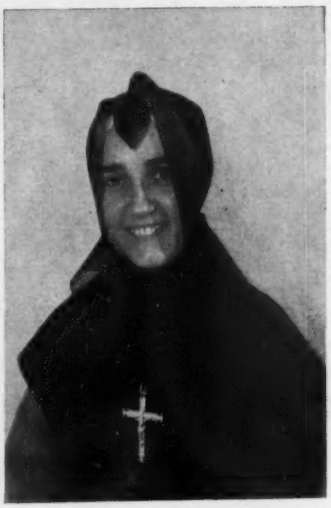
Gerald P. Turner Takes Post at Mount Sinai

Gerald P. Turner has been appointed assistant administrator at the New Mount Sinai Hospital, Toronto, Ont., and began his duties in July. He is a graduate in pharmacy of the University of Manitoba and received his diploma in hospital administration from the University of Toronto. He served his administrative residency at the St. Boniface Hospital, St. Boniface, Man., prior to joining the staff of New Mount Sinai Hospital. Mr. Turner is a member of the American Hospital Association.

* * * *

Appointed Director, School of Nursing

Sister Jeanne Quintal, s.g.m., was recently appointed Director of the School of Nursing of St. Paul's Hospital, Saskatoon, Sask. She holds a Bachelor of Science degree in nursing education from the University of Montreal and has had many years of administrative experience in the hospital field. She was formerly assistant administrator at St. Paul's Hospital, a post she held for five years.



Sr. Jeanne Quintal

* * * *

Peter Smith, Phm.B., New Administrator at Woodstock

Woodstock (Ont.) General Hospital's new administrator is Peter Smith, Phm. B. A native of Edinburgh, Scotland, Mr. Smith received his degree from the Ontario College of Pharmacy and has worked for the past 14 years for Abbott Laboratories Ltd., Montreal.

* * * *

Jean MacLean

Jean MacLean, who retired last autumn from her position as director of the School for Nursing Assistants at Camp Hill (D.V.A.) Hospital in Halifax, died in May of this year. Miss MacLean graduated from the Toronto General Hospital and ob-

(Concluded on page 126)

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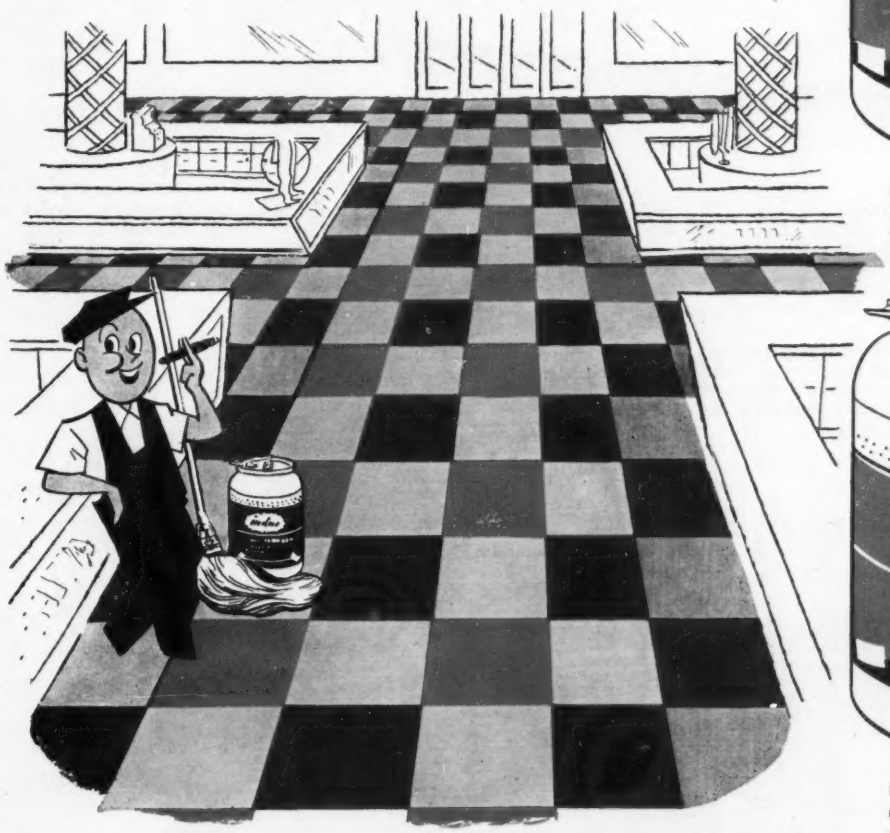

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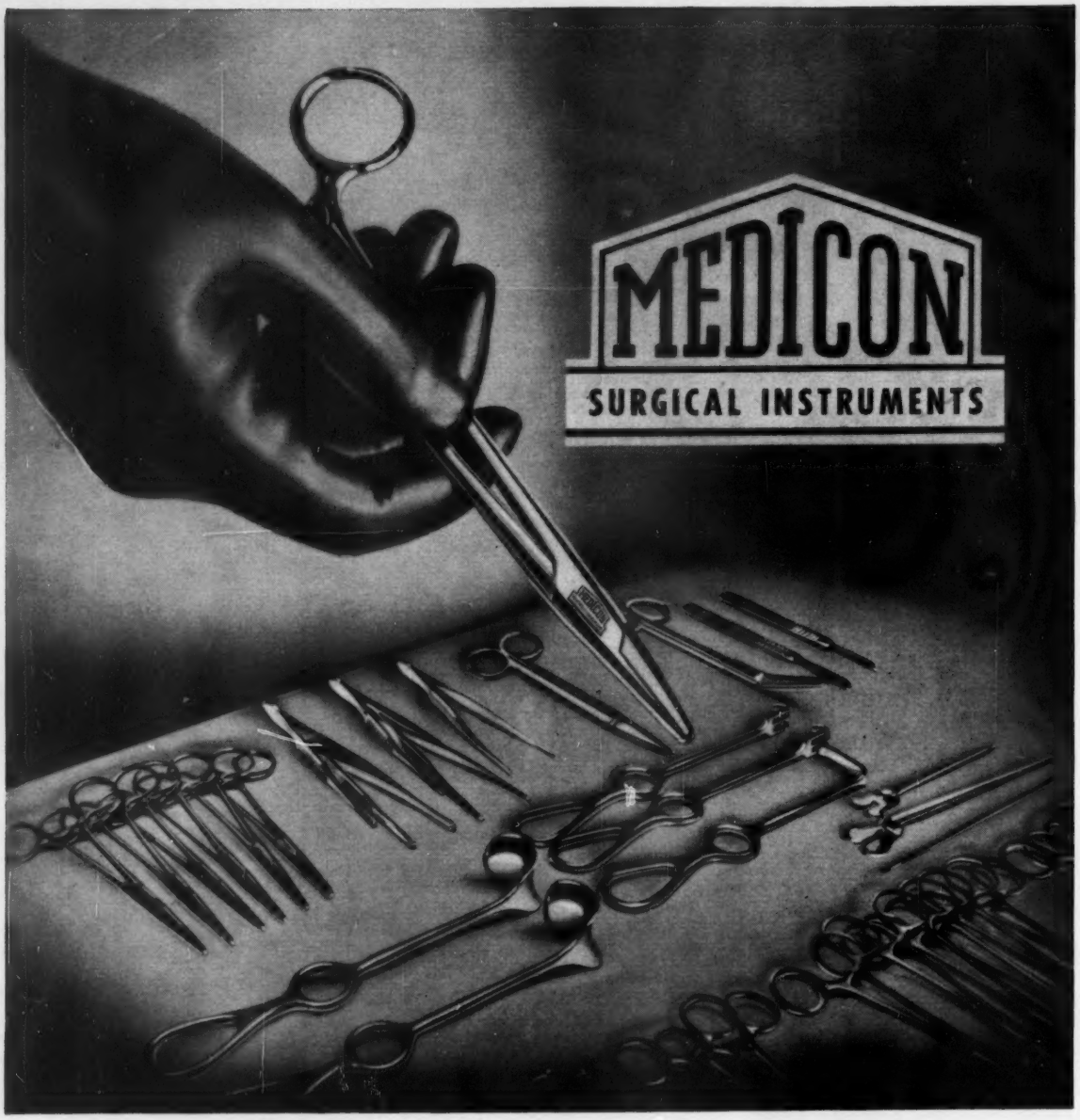

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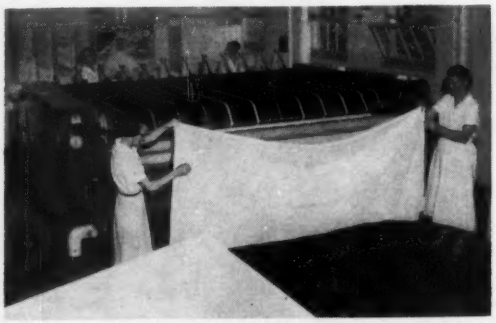

Here, Sister Floracita supervises operation of the hospital's new Super Sylon Ironer, also a recent installation by Stanley Brock Ltd.

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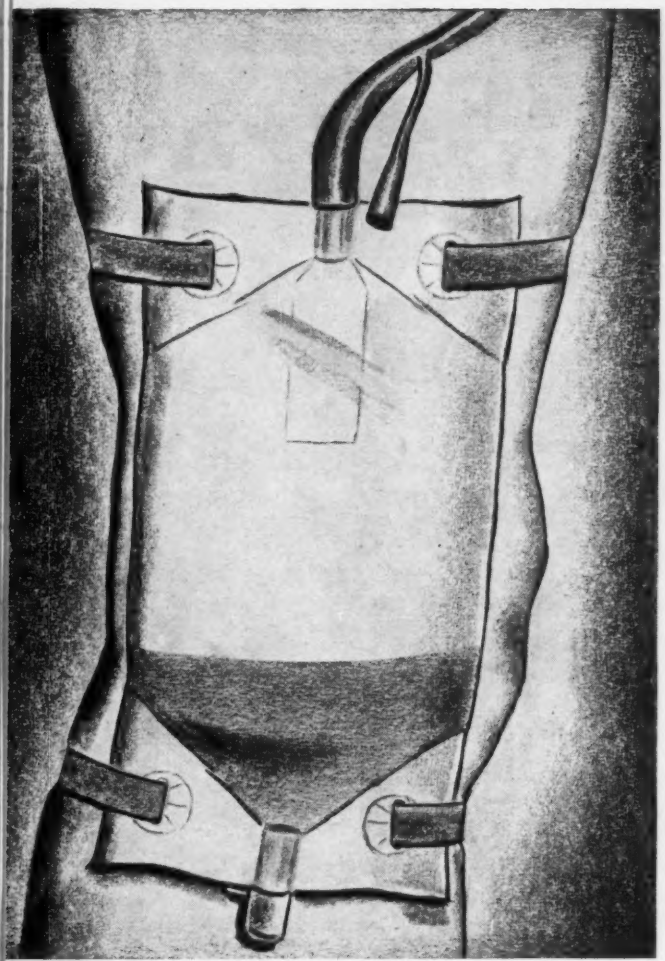

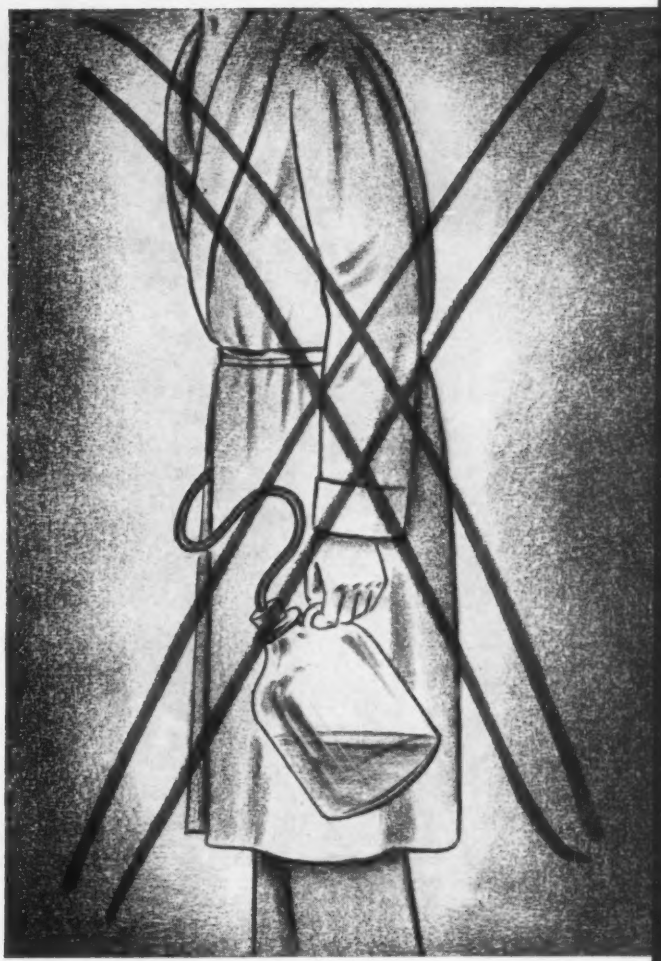

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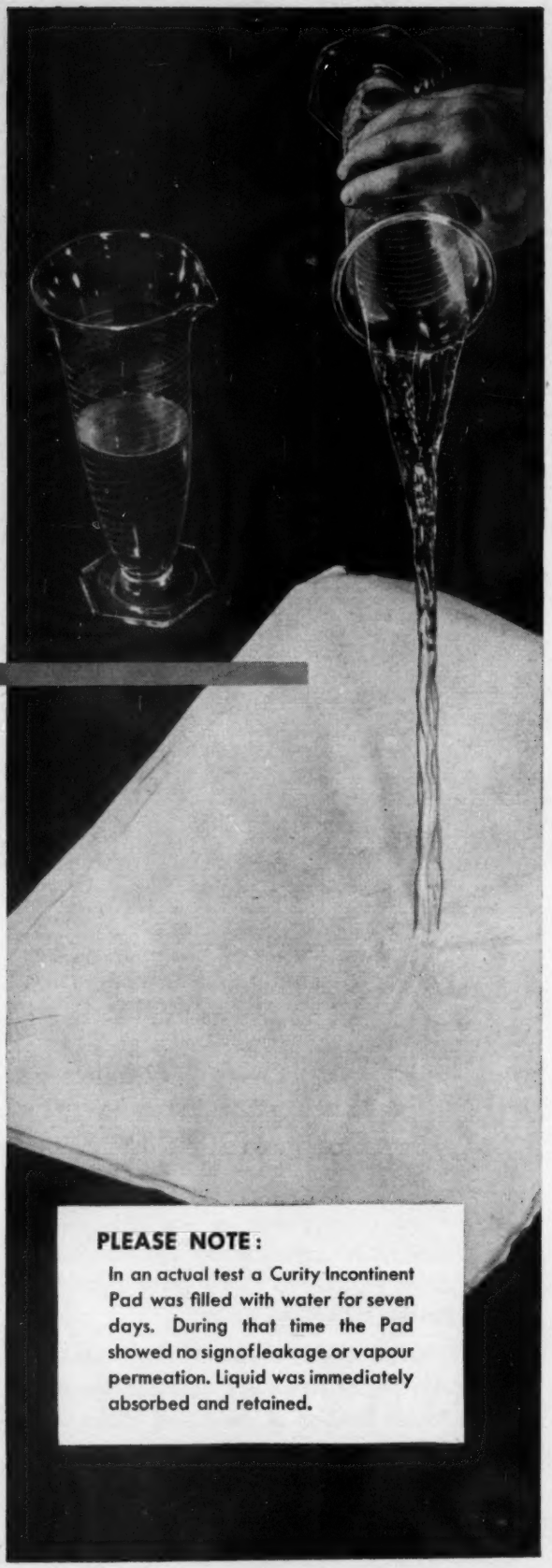

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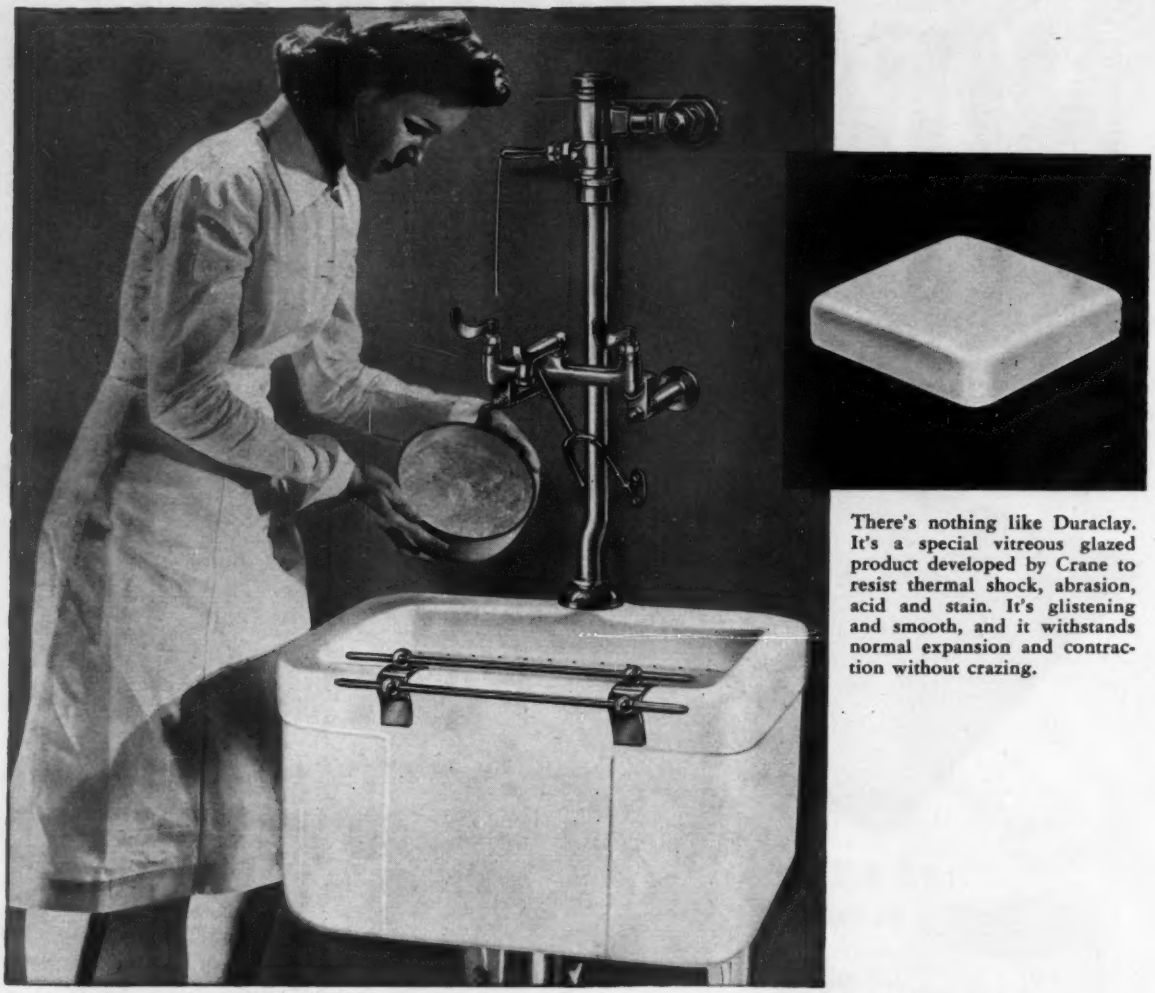

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Featuring University Hospital, Saskatoon

THROUGHOUT 1955 all parts of Canada have echoed to the celebrations being held in Alberta and Saskatchewan in commemoration of the 50th anniversary of the entrance of these provinces into confederation. The opening of memorial buildings, and the publication of innumerable books, brochures, and special newspaper editions, have taken place with great fervor and amid much jubilation.

One achievement in Saskatchewan, which will be a continuing source of pride to its citizens long after the Golden Jubilee celebrations have faded into memories, is the opening of the new University Hospital in Saskatoon. With its exterior matching and harmonizing with the surrounding buildings, the hospital has become the dominating architectural feature on the beautiful grey stone campus of the University of Saskatchewan, overlooking the winding South Saskatchewan River.

In this issue, commencing on page 37, we publish a series of six articles featuring the new hospital. Included are seven floor plans. We are indeed indebted to Dr. Arnold L. Swanson, the Executive Director of the hospital, and his associates for contributing these articles so soon after the official opening. Additions to and even the complete re-building of existing hospitals are not infrequent occurrences today. The creation of an entirely new teaching hospital of over 500 beds is not common however. Furthermore, as Dr. Swanson points out, the establishment of a new medical school in Canada is not an everyday occurrence.

The University Hospital, Saskatoon, has many fine features. One that is a bit unusual is the location of the dietary department on the top floor. From the adjoining cafeteria the staff has an almost unobstructed view of the beautiful surrounding city and countryside. Perhaps this was a deciding factor in the department's location. We believe that our readers will find much of interest in the articles and the floor plans of Canada's newest teaching hospital.

Psychiatric Care and the General Hospital

IN HIS ADDRESS to the 13th biennial meeting of the Canadian Hospital Association, the Honourable Paul Martin, Minister of National Health and Welfare, spoke at some length on the question of mental health. (See *Canadian Hospital* June, 1955, page 37). Mr. Martin stated that, since 1948, we have succeeded in substantially increasing the number of mental hospital beds in Canada and have done a good deal to decrease overcrowding and to improve treatment facilities. However, there has not been a significant increase in the ratio of beds to population and overcrowding in mental hospitals is still far from being eliminated. The Minister stated also that the establishment of psychiatric units in general hospitals is becoming increasingly prevalent. There is great scope for psychiatry within the general hospital, he said, because there are, within most communities, a sufficient number of psychiatric cases to keep such units fully occupied. He cautioned, however, that there are limits to what the general hospital can do in this field.

Mr. Martin's statement that there is a very high rate of re-admission to mental institutions (almost one-third of the patients entering each year are re-admissions) will be a new thought to many who read this journal. These

are patients who have been made well enough to return to their homes and to their communities but who have not been able to remain well outside the hospital. Mr. Martin suggested that perhaps there must be more active follow-up of patients discharged from the hospital and more done to help them readjust to their family, work, and community. The Minister was right when he stated that this is a situation with which we must all be concerned.

It is true there is a growing awareness of the need for more understanding of the psychiatric patient and of the growing role which the general hospital is called upon to play today in the treatment of the early phases of mental illness. However, it takes time to change the thinking of the whole nation. While it is heartening that health leaders recognize the vital importance of good mental health, there is still a great need for enlightenment among hospital people (and the general population) in the understanding of the over-all problem and the part each of us must play before the mental health picture will improve materially.

The community's attitude toward mental illness has changed many times through the ages. There was a period of persecution followed by segregation and later a more humanitarian attitude was adopted. Recently the community has attempted to develop a scientific approach. The concept of insanity as an illness has developed very slowly among the population and it is only very recently that much thought has been given to preventing mental illness before it develops. Today the public is gradually accepting the idea that mental illness is a disease like any other. It is being recognized that patients suffering from mental illness respond to treatment and that this response is more pronounced when the patient is treated early.

Dr. Francis J. Braceland, Director of the Institute of Living at Hartford, Conn., stated in a guest editorial in the August, 1955, issue of *Hospitals*, official journal of the American Hospital Association:

"All hospitals should be in a position to provide psychiatric diagnosis and consultation and care for the acute and milder forms of mental and emotional problems . . . It is only through the interest and co-operation of physicians and hospitals in the community that real progress can be made in the diagnosis, treatment and prevention of mental disorders and the myriad physical disabilities that are rooted in the emotions. The increasing provision of psychiatric units in general hospitals is a heartening trend of medicine in mid-century, but as yet it is only a trend. It cannot be emphasized too strongly that all hospitals should be in a position to provide psychiatric diagnosis and consultation and care for the acute and milder forms of mental and emotional problems which are encountered daily. The distaste for, or the misunderstanding of, psychiatric problems is an incubus that retards the progress of medicine. The provision of adequate facilities and personnel for psychiatric work in general hospitals will be amply repaid in many ways in benefits to both the hospitals and to the society that hospitals are dedicated to serve. Psychiatric patients are not a people apart. They are 'thee and me' under the influence of time, pressure and circumstances."

While today we are removed from the ages which thought of psychiatric cases as demons, cast them into dungeons, burned them as witches, or segregated them merely to keep them out of society, there is still need for more understanding of such patients in the community. There is a need also for an increasing awareness on the part of hospitals, if they are to make claim to the word *general*, that they have a duty to the community to provide short-term facilities for the milder forms of mental and emotional upset.

Sometimes one hears criticism of the various subjects which student nurses have to study during their training. A recent addition to their curriculum has been psychiatric nursing. Remembering that a large percentage of all patients have symptoms of an emotional origin, how can we expect to have better understanding among our hospital personnel and community if young nurses are not given ample opportunity to study this very important phase of health care?

Even with present difficulties in advancing the cause of better care and understanding of all facets of psychiatric care, steady progress is being made. The great increase in adequately trained personnel in the medical and nursing fields, the greater utilization of trained psychiatric, social, and other workers, the establishment of mental health and child guidance clinics, the provision of more beds in mental institutions and in psychiatric units of general hospitals, a more enlightened community—all of these are in evidence. Undoubtedly over the next few decades the advancement in better psychiatric care will be one of the notable contributions of medical science.

"It's Your Hospital"

WHEN PRESS and hospital relations are being discussed, one frequently hears the statement made by hospital people that newspapers are interested only in sensational news about the institution and its patients. While this seems to be a wide-spread opinion it is not basically true. Recently Dr. G. Harvey Agnew, President of the Ontario Hospital Association, has prepared a series of articles under the title "It's Your Hospital"; and some 60 daily and weekly newspapers throughout Ontario are now carrying these articles in their columns. The present series of articles, which are released twice a month, is 26 in number. They cover many phases of hospital service and some 13 have now been published.

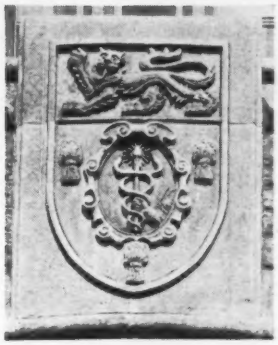
The Ontario Hospital Association has for some time felt the need for providing the press with authoritative, factual outlines of the hospital's role in community life. The number of papers now participating shows that newspaper editors are only too anxious to inform their readers on various aspects of any central community service of which the hospital is one important example.

It is estimated that one out of every eight persons are patients in our hospitals during a given year. It could be argued that in eight years the majority of the population will know considerable about hospitals and, therefore, the population will be reasonably well-informed about them. However, with the growing complexity of hospitals, there is undoubtedly a great need to present to the public articles such as those prepared by the Ontario Hospital Association —fundamental facts about hospitals, their organization, function and problems. Hospitals have a real story to tell and articles such as Dr. Agnew's should stimulate public interest and understanding.

A Concept:

Canada's Newest Teaching Hospital

A. L. Swanson, M.D., M.H.A.,
Executive Director,
University Hospital,
Saskatoon, Sask.



*Hospital Crest**

THE INTEGRATION of University Hospital, Saskatoon, with the College of Medicine and with the total health education program in Saskatchewan has presented a challenging concept. It is not common for a community to build a hospital of over five hundred beds as a completely new entity. Usually construction of this extent replaces or adds to an existing building. Likewise, medical schools are not established as an everyday occurrence. The completion of such a hospital, concurrent with the expansion of a College of Medicine into a full-fledged four-year course, therefore represents an undertaking that by its very rarity is of interest.

General Administration

Although the hospital and college are part of a total endeavour, they are organized as separate administrative units. The college, headed by the Dean of Medicine, is responsible to the University Board of Governors. The hospital, headed by the Executive Director, is the charge of an independent board—known by statute as the "University Hospital Board". This latter body of seven members is composed of three university representatives of which the President and Dean of Medicine are named *ex officio*. With exception of the two members *ex officio*, the board is appointed by the Lieutenant Governor in Council and holds office for three years. Despite the obviously close ties to university and government, the hospital is neither "University" nor "Civil Service", but functions much like any other hospital in the province.

In the interest of smooth day-to-day operation, the Executive Director and the Dean work in close co-operation. For major policy decisions which affect both institutions, a "Joint Committee on University-Hospital Relationships" has been established. Equal representation from the hospital and university boards constitute the membership and decisions must be approved by each organization. Thus, while the two institutions are physically contiguous and the closest administrative liaison exists, each may individually pursue its particular hospital or college activities.

Medical Staff Organization

Two points should be mentioned—the first being that the professors of clinical subjects in the college are automatically chiefs of their respective departments in the hospital. This trend is carried forward to a considerable degree in the other Saskatoon hospitals where various departmental chiefs also hold teaching appointments in the college. All other members of the medical staff of University Hospital also hold teaching appointments in the college as a requisite for their hospital appointment. The departmental chiefs at University Hospital are full time at the hospital and medical college. Although they are permitted and encouraged to develop a limited private practice, this activity is confined to referred cases from other physicians. Department chiefs, by being full-time and only partially dependent on private income, have much more time to organize and administer their academic and clinical programs for students. Their offices are located in the hospital or college and thus they are "geographically" full-time, even when engaged with private consultative duties.

A. L. Swanson, M.D.

The second point of particular interest is the emphasis on training for general practice. As a teaching centre in a predominantly rural agricultural province, it is desired to concentrate on producing good doctors (and other health personnel) for general practice. A Department of General Practice has been formed with every good intention on the part of the hospital to make it an active administrative department. Although its members are attached to clinical departments for the admission and care of patients, it is the aim to encourage participation by the Department of General Practice in all other phases of hospital activity and to develop an active educational program.

Nursing

From its outset, the University Hospital has joined the ranks of those hospitals which separate nursing ser-

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* *The distinctive University Hospital crest over the main entrance incorporates the crest of Sir William Harvey into the province of Saskatchewan shield. When Sir William was at the University of Padua the university erected the crest in his honor and entitled it "The Englishman".*

View of the hospital and medical college. The hospital laundry building is partially visible behind the medical building. The north wing of the nurses' residence is on the extreme left of the picture. Saskatchewan River in background. — University News Service Photo.

vice from nursing education. Often lauded in principle, the procedure requires careful planning in reality. Our students are either enrolled in the three-year "diploma" course or are engaged in the nearly five-year "degree" course. Both groups are enrolled as university students and during their phase of hospital experience are under the continuous guidance and direction of their faculty of academic professors and clinical supervisors. Their periods of work on the wards of the hospital are carefully timed and integrated with their educational program and bear little, if any, relation to hospital shortages or other needs. Like nurses from other Saskatchewan hospitals, our diploma nurses begin their course by taking their first four months as a purely academic experience in a centralized lecture program. Although living in the hospital, they do not commence their clinical experience until the fifth month. Conversely, their later periods of training are almost exclusively of a practical nature under supervision in the hospital. During their full three years they remain registered in the university, have student recreational privileges and are encouraged to be part of the university as well as of the hospital. The potentialities of such a program are vast indeed and the results during the next few years will merit careful reporting.

The Structure

The accompanying plans and the articles on certain departments will give some idea of this multi-million dollar development. A few points, each of which might provide subject matter for an article, should be mentioned.

1. There is a sub-basement beneath six of the seven hospital wings. The provision for storage space is thus very large and one perennial hospital problem is minimized. The area also suggests possibilities for civil defence planning.

2. The modern laundry has been built with an eye to the future with provision for considerable expansion of facilities.

3. The university has made a particularly generous allotment of land for buildings and grounds permitting adequate parking and access facilities.

4. We have been able to profit from the vast experience gained during the recent years of active hospital building and space requirements for most departments have been incorporated initially as specific parts of the structure. We are far from perfect but do have space provided for social service, physiotherapy, occupational therapy, and other departments that have been overlooked in many hospitals in the past. (Even so, we still have our spatial problems!)

5. The main kitchens and cafeteria are on the top floor. Most of us (the author included) have been impressed with the desirability of a ground or main floor location. It must be said that, if nothing else, our exception proves the rule. When there is a good view, when many cleaning and preparation facilities can be located near the receiving entrance so that garbage is not hauled up and then down, and when elevator service is adequate, the advantages to staff and visitors are tremendous. Thus far we regard our top floor location as a large asset.

6. A large pharmaceutical manufacturing area will permit both training facilities for pharmacy students and a considerable saving in drug costs.

7. Labour- and time-saving equipment has been extensively utilized. In these days of labour shortages and increasing labour costs the right machines help to reduce the number of staff required and quickly pay for themselves.

8. In keeping with the teaching aims for which the hospital was built, there are twelve multi-purpose rooms for student teaching, student laboratory work and patient examination, in addition to two large lecture theatres.

The University Hospital, Saskatoon, was conceived as an essential teaching arm in the development of medical education and health care in Saskatchewan. As such it was born and as such it has just begun to function with student nurses, technicians, pharmacists, interns and others playing a part in its evolution. As a medi-teaching institution in the broadest possible sense, the first obligation becomes the optimum care of its patients and it is on the basis of this objective that all teaching aims are founded. Thus the care of the patient forms the framework of our threefold objective; teaching forms the body; and research is the motive power for progression.●

University Hospital—

An Architect's Tour

E. J. Gilbert, F.R.A.I.C.,
Saskatoon, Sask.

PRIOR TO 1945 all buildings in the "stone area" of the University of Saskatchewan campus were of Collegiate Gothic design and this style was strictly followed. The result was a unified group of buildings greatly admired by all who saw it.

The architects for the medical group were instructed to carry on in the same style. Webster and Gilbert were the local architects chosen for the hospital, with the well known Toronto firm of Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside as associates. Dr. Basil MacLean, now Commissioner of Hospitals for New York City, acted as consultant in the early stages of planning. The architects are also indebted to Dr. W. S. Lindsay, Dean Emeritus of Medicine, all members of the hospital board and hospital staff for suggestions and guidance.

The Toronto architects made the preliminary plans, showing the size and shape of the building and the area and location of the various departments. These plans were turned over to Webster and Gilbert for the preparation of working drawings, specifications, details and supervision.

This explanation of the division of responsibility is made to relieve our eastern associates of blame for what many contemporary architects regard as an archaic design. We make no apology.

Most contemporary building design is dominated by vast expanses of glass, whether or not the glass is needed. In Saskatchewan the temperature ranges from 40 degrees below zero in winter to the high 90's in summer. Excessive glass areas mean excessive heat loss in winter and high fuel bills. Conversely it means high heat infiltration in summer, when the sun shines upwards of sixteen hours a day. It is illogical to provide acres of glass to let in the light, acres of drapes to keep out the light and spend money for the life of the building on excessive drapery replacement and laundering.

Specially designed steel sashes were used on the building with window glazing units. The centre sash opens fully so that the most timid maid could, if necessary, clean the glass on both sides without leaving the room. The sashes provide adequate light and ventilation.

Materials and Construction

The building is of fire-resistant construction throughout. The frame is structural steel with steel floor joists. Floor slabs are of reinforced concrete.

The exterior walls are limestone rubble with *Tyndal* cut stone trim. This matches other university buildings in the "stone area". The rubble was obtained locally. Originally it was deposited in the Saskatoon district by glaciers from bed rock in the vicinity of the Churchill River.. Stone is trimmed on the job with backs left rough. It is laid up in lifts of from three to four feet and concrete is poured against the stone facing. This produces a very strong wall of good appearance.

Partitions are constructed of terra cotta tile. Corridor and washroom dadoes are ceramic tile. Floors throughout are terrazzo or linoleum. Ceilings in corridors and noisy areas are acoustic tile. All stairways are enclosed by fire doors and fire doors are placed at strategic points in the corridors.

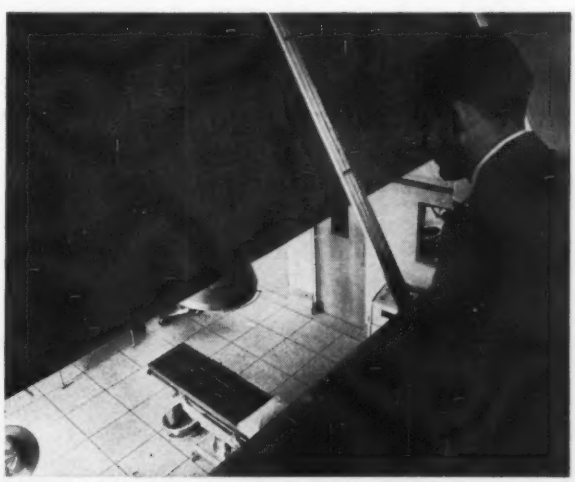
The general contract was carried out by Smith Bros. & Wilson Ltd., of Saskatoon.

Mechanical and Other Services

Steam is generated in the University Power House and brought through a service tunnel to the building at 125 P.S.I. pressure. Three equipment rooms are provided where the steam is reduced to the required pressure for sterilizing, cooking and heating.

A differential steam heating system was installed in nine zones, each system thermostatically controlled. Vacuum and return pumps are located in the three equipment rooms.

Power cables are brought through the service tunnel to an electrical room in the basement. A bank of transformers step it down to the required voltage. In case of power failure an auxiliary generator automatically cuts in to take care of operating room and other essential lighting. A standby



A view from one of the operating room galleries. A surgeon may speak to students through an inter-communication system. Operations may be televised to the hospital lecture theatres. —Sask. Govt. Photo.

generator in the power house will take over the entire hospital load in about ten minutes.

Air conditioning is provided for the operating rooms, nurseries and in special wards for "allergy patients". Exhaust ventilation is provided for toilets, inside rooms, and similar areas.

Water from the city mains is softened in the laundry building and boosted in pressure to serve the hospital and nurses' residence. All water used in these buildings is softened. Standby pumps and pressure system are provided and a large standby reservoir supplies the institution in case of a break in the city mains. Water is distilled at a central plant on the upper floor and distributed by gravity where required.

A hardwater main surrounds the group of medical buildings with fire hydrants and lawn-watering facilities.

Elevators

The building is served by six elevators and three dumb-waiters. Two elevators are assigned as service elevators. The passenger elevators can be operated either automatically or by attendant. They are of the collective pushbutton type. The nearest elevator will respond to a call irrespective of which button is pushed. All elevators are equipped with passenger cabs and all travel at the same speed.

Pneumatic Tube System

A pneumatic tube system with central station in the basement serves the hospital. Sub stations are provided at strategic points including all nurses' stations, record room, pharmacy and operating suites. The 12" carriers will take medicine bottles and similar bulky articles as well as requisition forms or even whole charts.

Reception and Administration

The waiting rooms and information desk are just inside the main entrance. A private branch telephone exchange is located at the desk. The elevator lobby is straight ahead of the waiting rooms, with the administrative offices occupying the main floor of Wing C adjacent. A snack bar and canteen is immediately to the right of the waiting rooms.

The admitting and emergeney departments are on the main floor of Wing D at the end of which are the ambulance entrances. The two doors for ambulances open automatically on the approach of vehicles. Two exit doors for ambulances are opposite the entrance doors so there is no snarling of incoming and outgoing traffic.

The emergency department is provided with nurses' station, operating and sterilizing rooms and examining rooms. Between the emergency and admitting departments are observation wards and a chest x-ray room.

Out-patient Department

The out-patient entrance is at the end of Wing E. A well-equipped out-patient department occupies the ground and main floors of Wing E. The ground floor of Wing D is assigned to psychiatric out-patients.

Personnel Office

The personnel office is on the ground floor of Wing B. This is located opposite the staff entrance. The time clock is mounted in the corridor opposite the entrance and staff lockers and rest rooms occupy the balance of the floor in this wing.

Also on this floor in Wing C are located two lecture theatres. Surgical operations can be televised and viewed in these rooms.

Stores

The goods-receiving entrance is at the back of Wing C and is at grade level. Here all supplies are checked in by the storekeepers. Refrigeration is provided for bulk storage of meats, dairy products and vegetables. Other supplies are chuted to storage rooms in the basement.

Blood Bank

The Red Cross Blood Bank occupies the ground floor of Wing G at the rear of the hospital. It is operated by the Canadian Red Cross Society for the collection, processing and distribution of blood for northern Saskatchewan. It also provides a direct blood bank service to University Hospital.

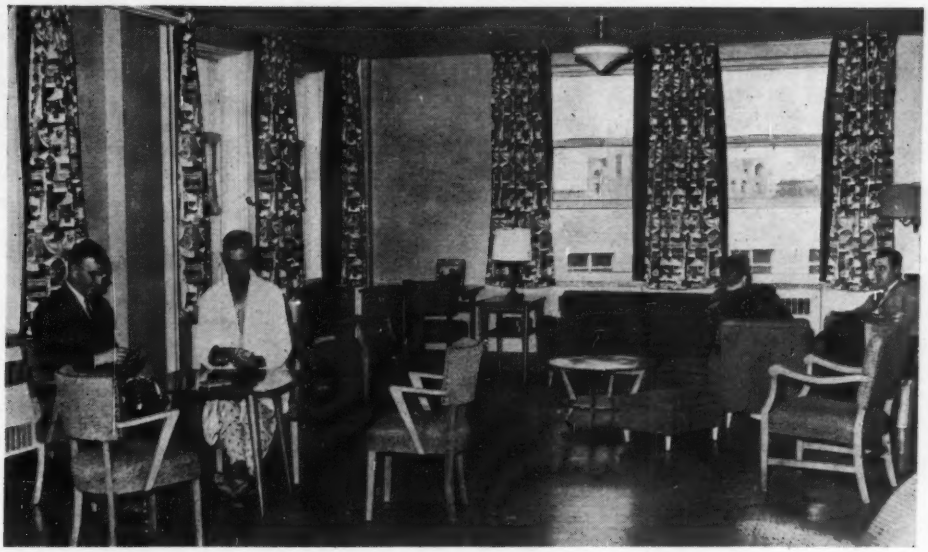
Cancer Clinic

The Cancer Clinic for northern Saskatchewan is located on the main floor of Wing G. It occupies the entire floor with further laboratories for cancer research on the ground floor of Wing F.

A separate entrance for cancer patients leads to the reception desk with a well-furnished waiting room adjacent. Separate examining rooms are provided for new patients and for repeat patients. Administrative offices for the clinic are on this floor.

The clinic also contains a minor

A private room. Note two-way "intercom" near head of bed. P.S. The rug won't slip—it has a soft rubber base. — Sask. Govt. Photo.



Patients relax with their visitors in one of the hospital solaria. — Star-Phoenix Photo.

operating room and therapeutic x-ray rooms. The famous Cobalt Bomb, one of the first of its kind to be put into use, is located here. In addition to its regular cancer treatment services, the clinic functions as the department of therapeutic radiology for the hospital and medical college.

Diagnostic x-ray and film processing for the entire hospital are located along the corridor in Wing F.

The research laboratories contain a special "hot lab" where radioactive isotopes are handled. This laboratory is specially designed with dressing and shower rooms for staff. Removable paint is used on all walls and furniture so that when radioactivity becomes excessive the paint can be peeled off and renewed.

Radioactive liquids are not allowed outside the area. They are administered in a treatment room adjacent to the "hot lab." This guards against contamination of the building through accidental spilling of the liquids.

Pathological Laboratories

Extensive pathological laboratories are located on the third floor of Wing G. The morgue and post mortem rooms occupy a portion of this floor adjacent to the rear service elevator. There are two well-lighted post mortem rooms with student galleries.

Operating Suite

The operating suite is on the second floor of Wing G and contains a total of twelve operating rooms. A special fracture room for complicated bone operations forms part of the suite. This room has a separate plaster room into which patients are moved for the application of casts. Two of the major operating rooms have galleries for student observation.

There are in addition well equipped rooms for cystoscopy, endoscopy, eye, ear, nose and throat, and dental work. Special x-ray equipment is provided here, as well as a frozen sections laboratory. The suite has the usual complement of sub-sterilizing rooms, scrub-up rooms, clean-up rooms, anaesthesia and recovery rooms, work rooms, lockers and lounges.

Obstetrical Suite

The obstetrical suite is on the fourth floor of Wing G and consists of three regular delivery rooms with an additional emergency delivery room. The suite has, in addition, labour rooms, preparation room, sterilizing rooms, scrub-up rooms, lockers and lounges.

The floors in the operating suite and obstetrical suite are carbon black conductive terrazzo, to eliminate sparks from static electricity.

Patient Accommodation

There are single, double and multiple wards. The largest wards contain only four beds and in most cases they are divided by low walls into two-bed units. Each ward has its own toilet accommodation. Toilets are fitted with bed pan cleansers and bed pans for each patient are kept in the wards. Utility rooms for bed pan sterilizing

The ward clerk controls her station with pneumatic tube, patient "intercom" and telephone all within reach.—Sask. Govt. Photo.

are provided at convenient locations.

The nurse call system is the combination visual-audible installation. When the cord button is depressed lights are illuminated at the bed, over the patient's door, on a light panel in the nurses' station and in the utility rooms. If the button is held down by the patient a buzzer sounds in the nurses' station. Should the nurse be in the corridor she may answer the call directly; should she be at the station, she may depress the appropriate key on the call panel and have direct conversation with the patient. If a nurse inadvertently or intentionally "listens in" to a patient's room, the light at the patient's bed goes on. It is reassuring to the patients to know that persons cannot "eavesdrop" without their knowledge, although the likelihood of busy nurses doing so is remote.

Oxygen from a large central liquid

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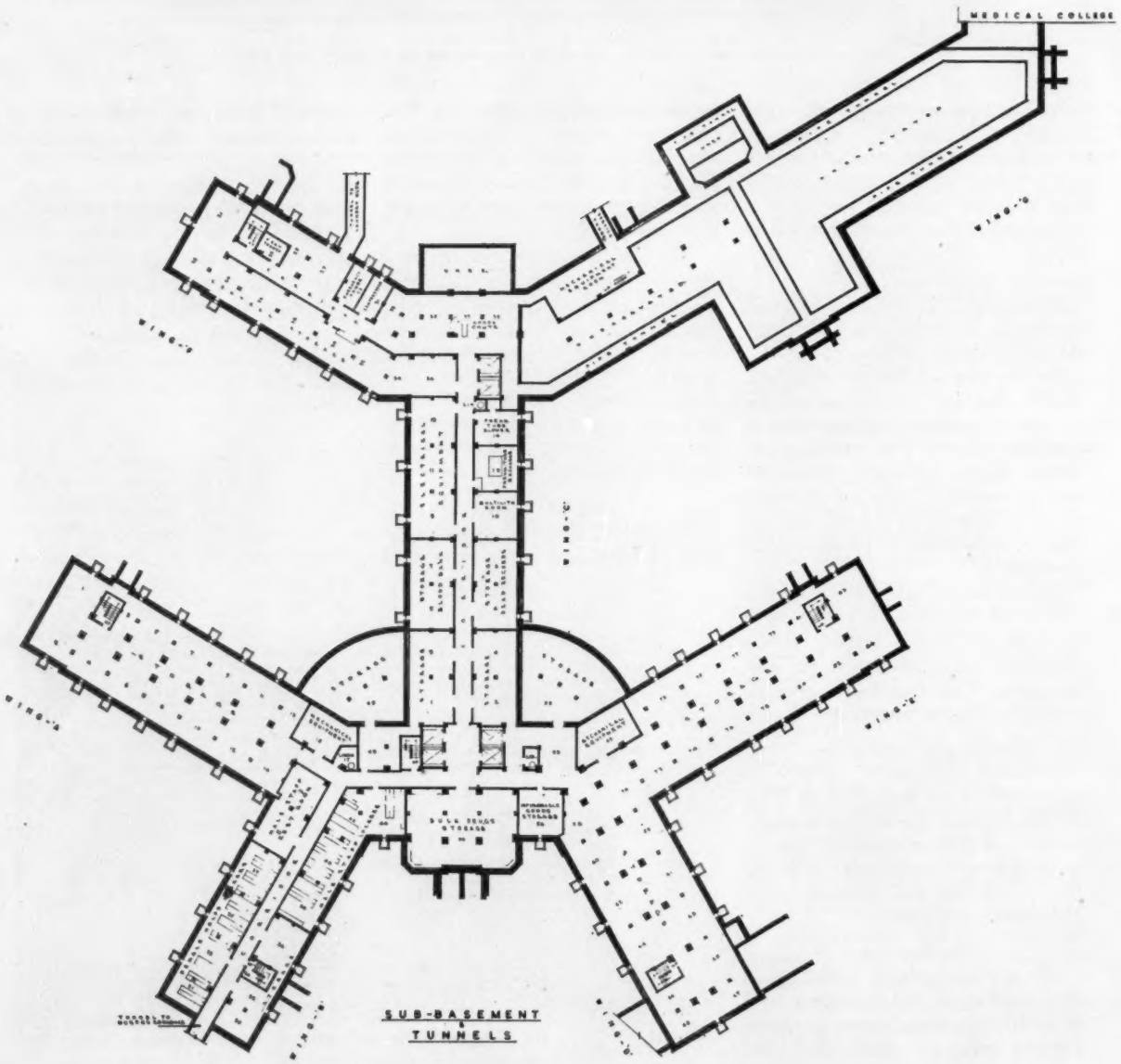
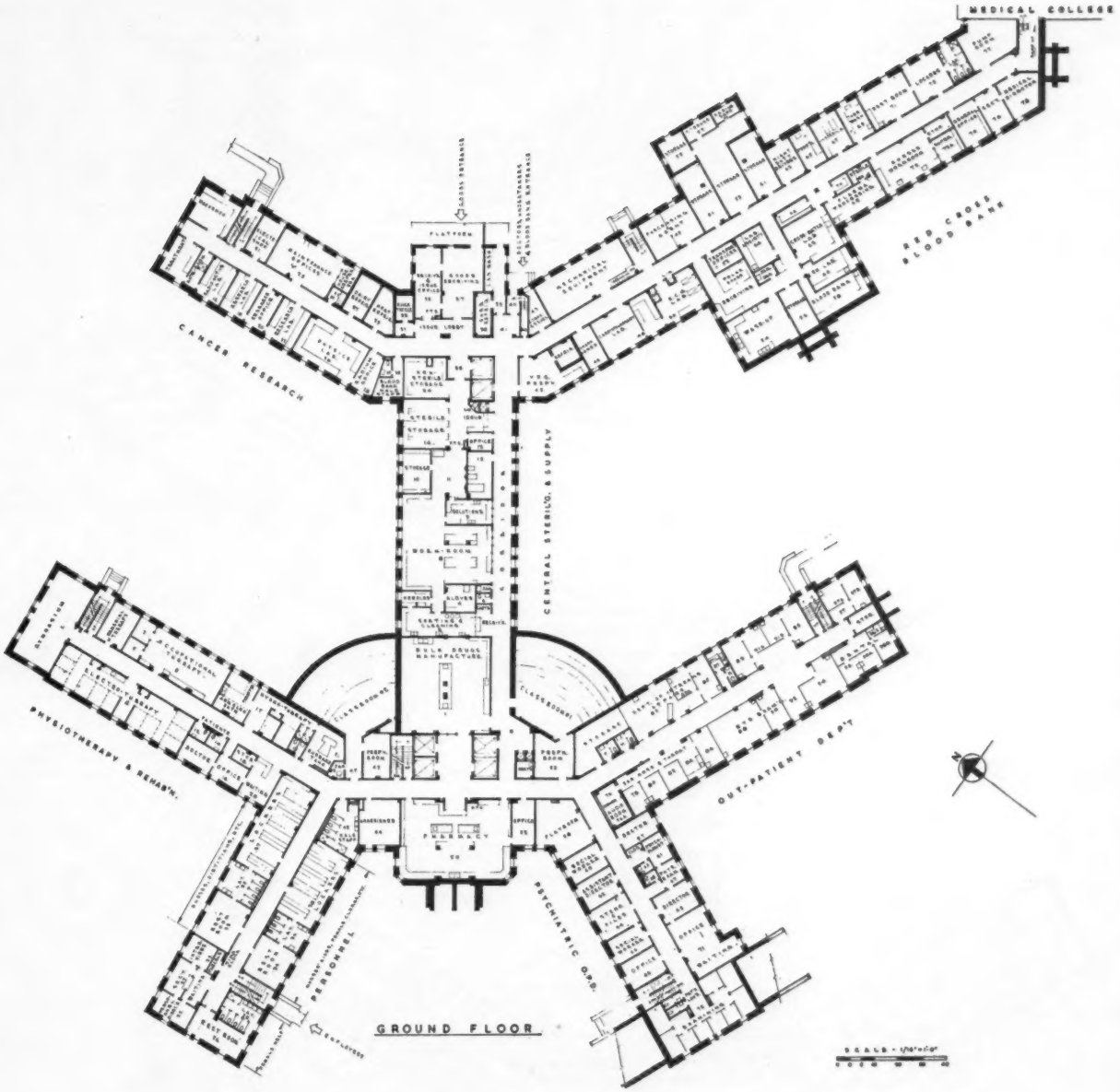


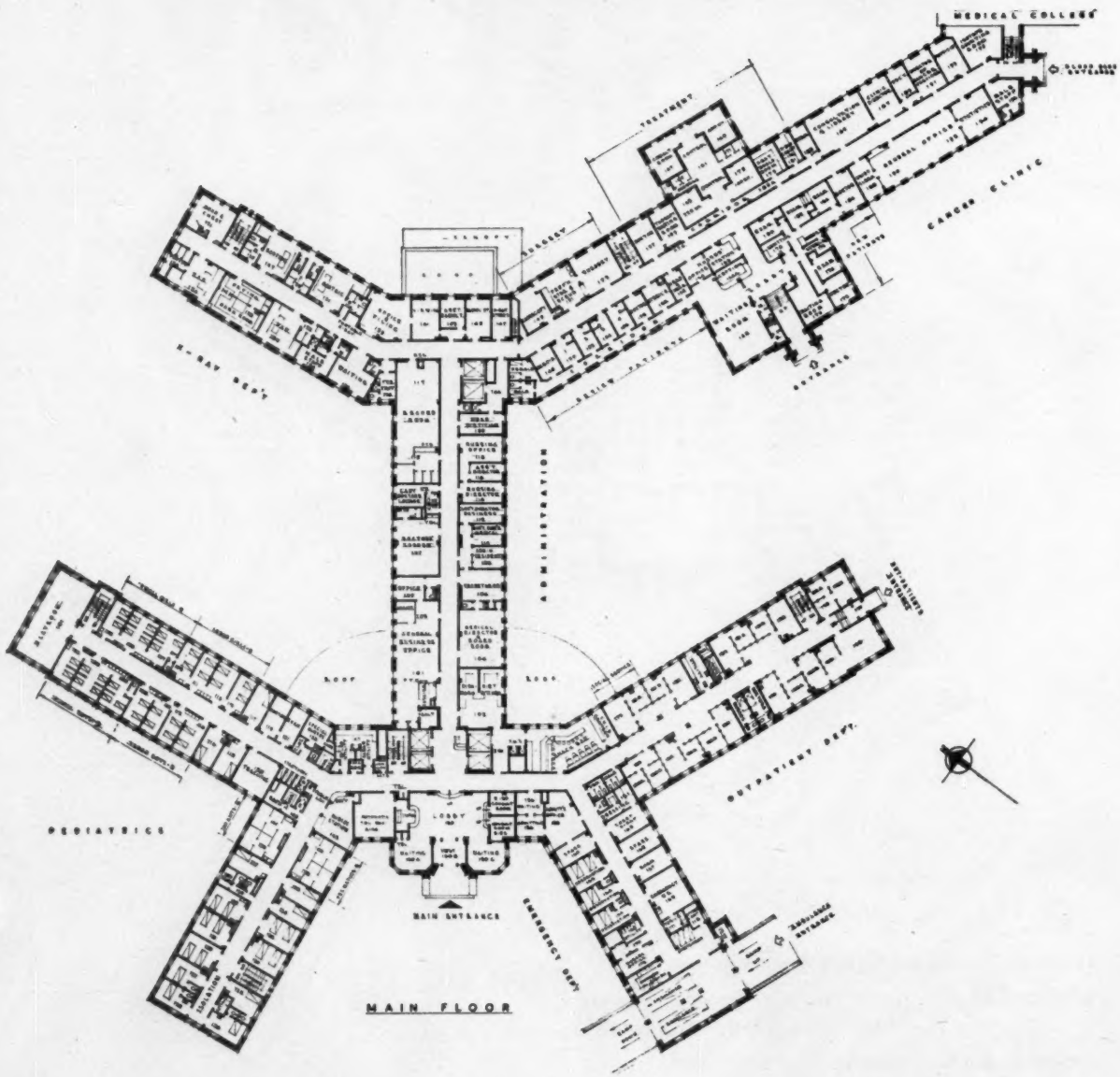


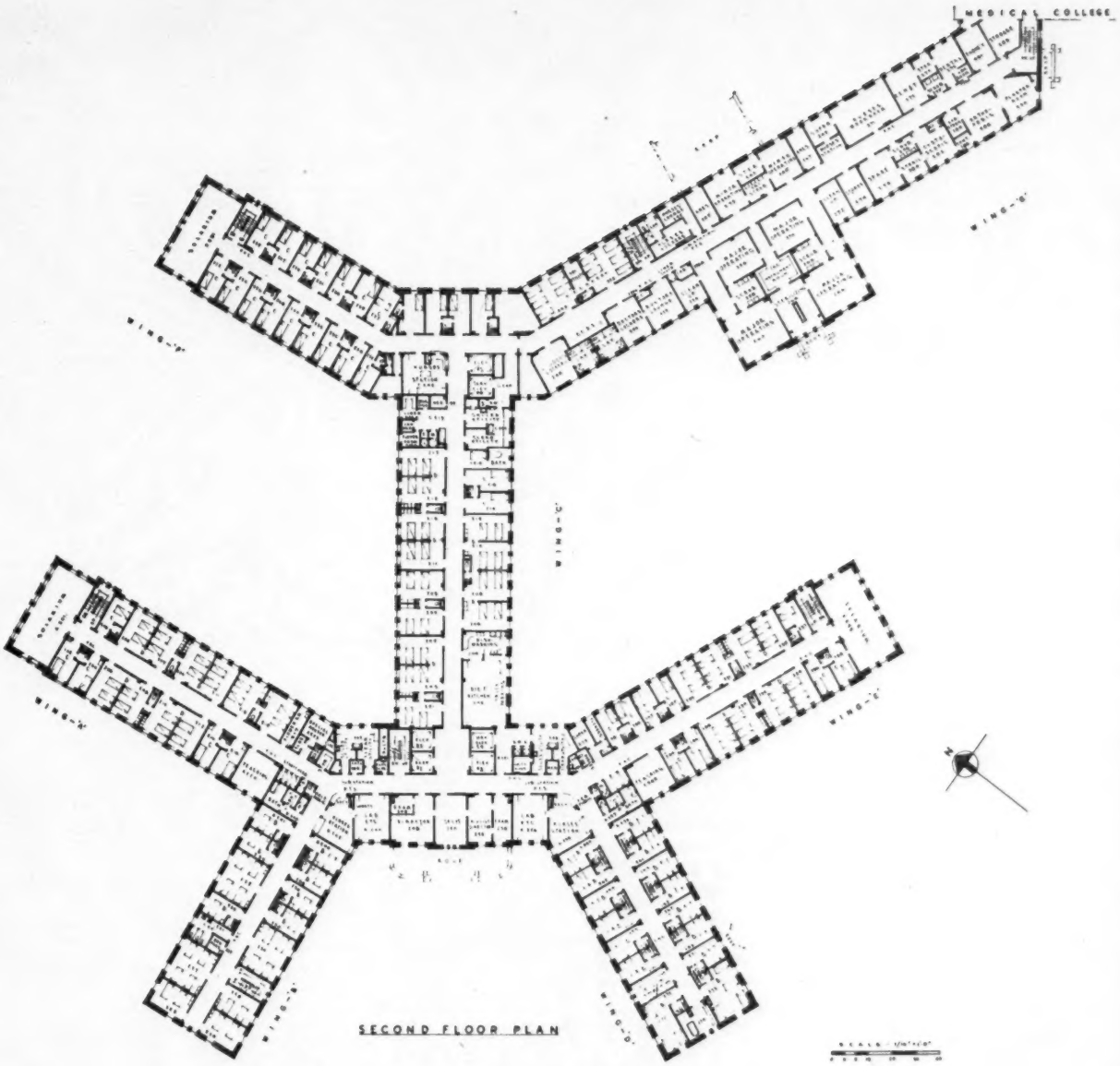
Architects: Webster and Gilbert, Saskatoon, Sask.

Associate Architects: Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto.

Consultant: Dr. Basil MacLean, New York City.

University Hospital, Saskatoon, Sask. . . .





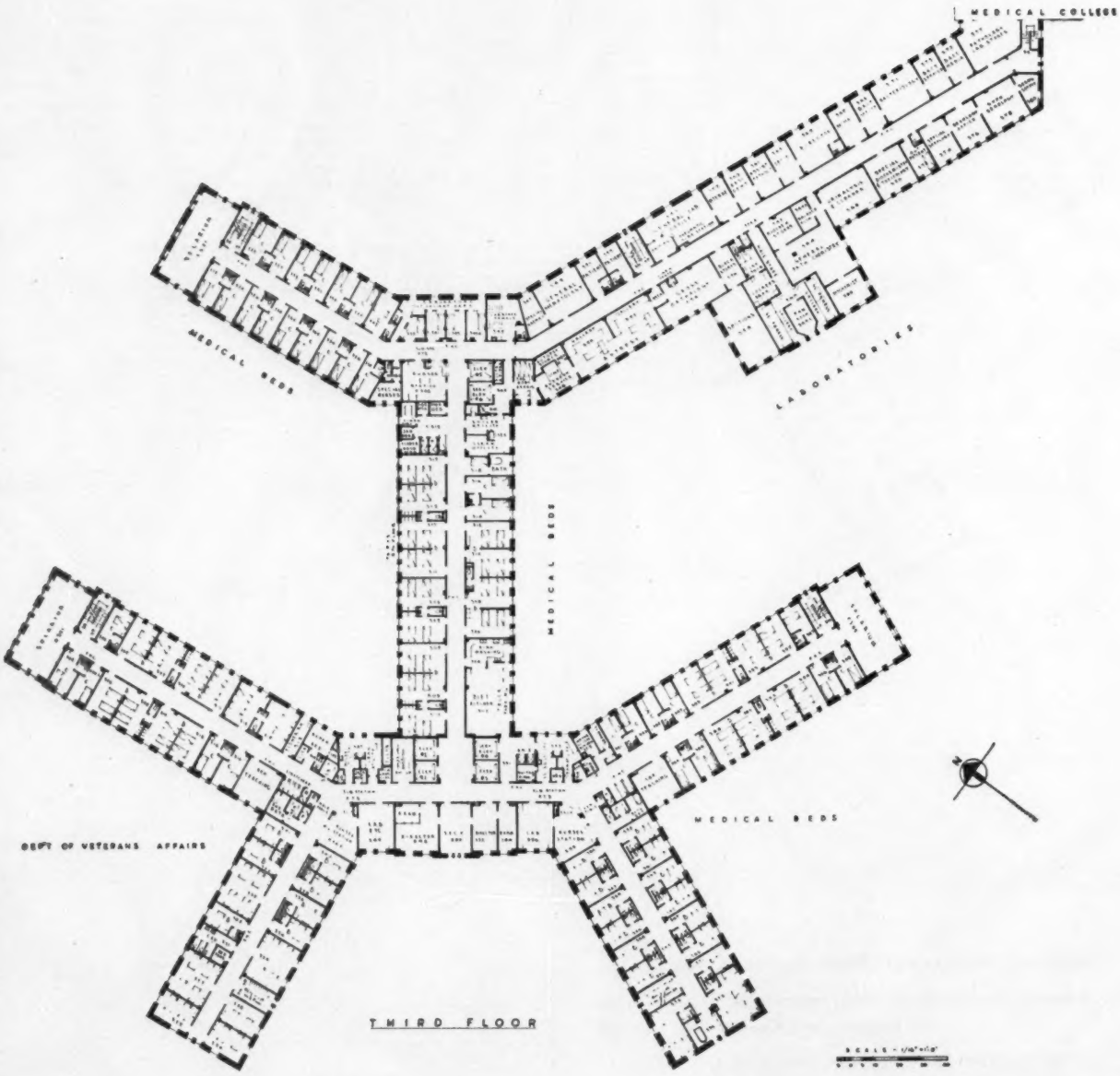
SECOND FLOOR PLAN

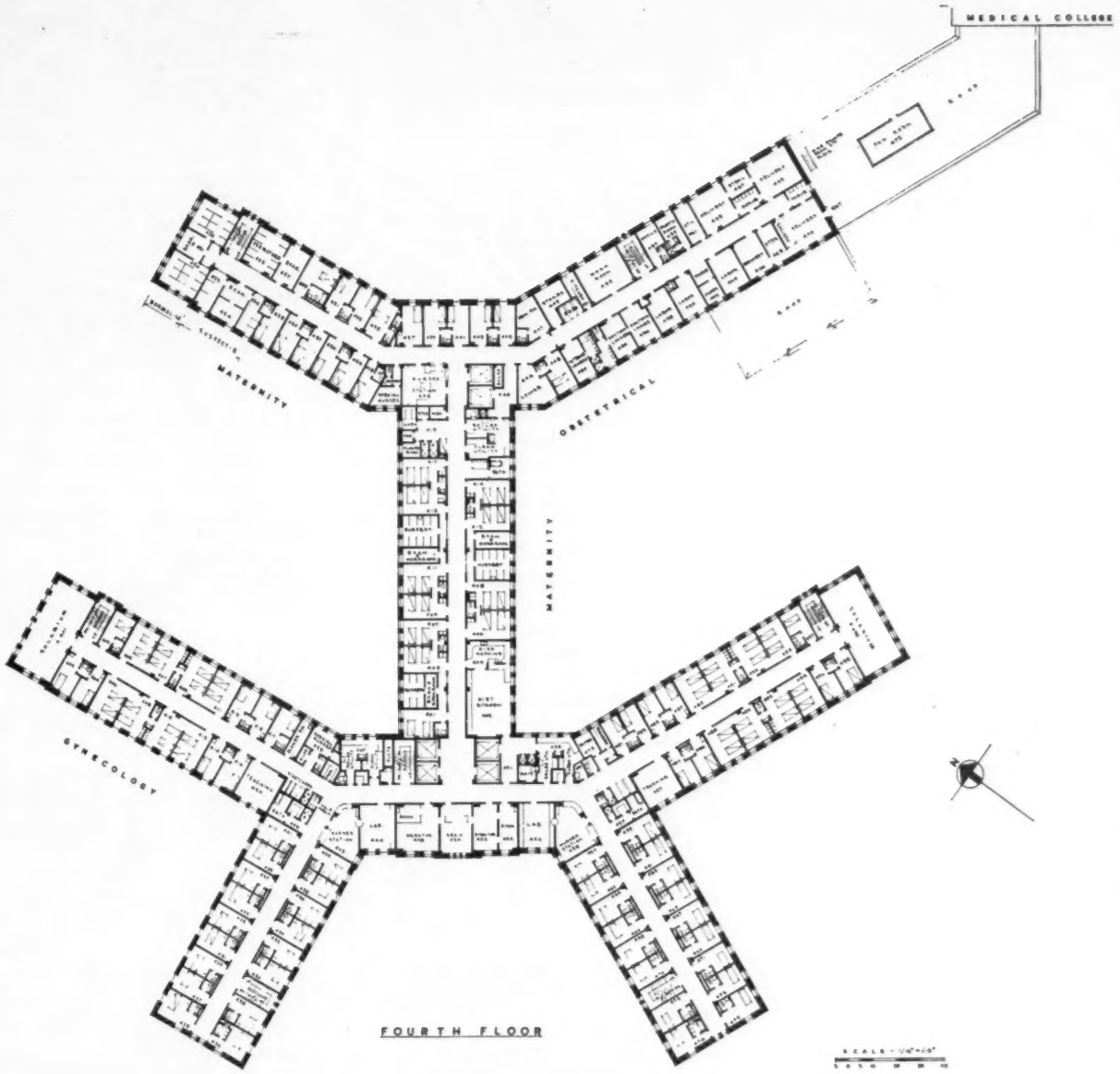
Architects: Webster and Gilbert, Saskatoon, Sask.

Associate Architects: Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto.

Consultant: Dr. Basil MacLean, New York City.

University Hospital, Saskatoon, Sask. . . .

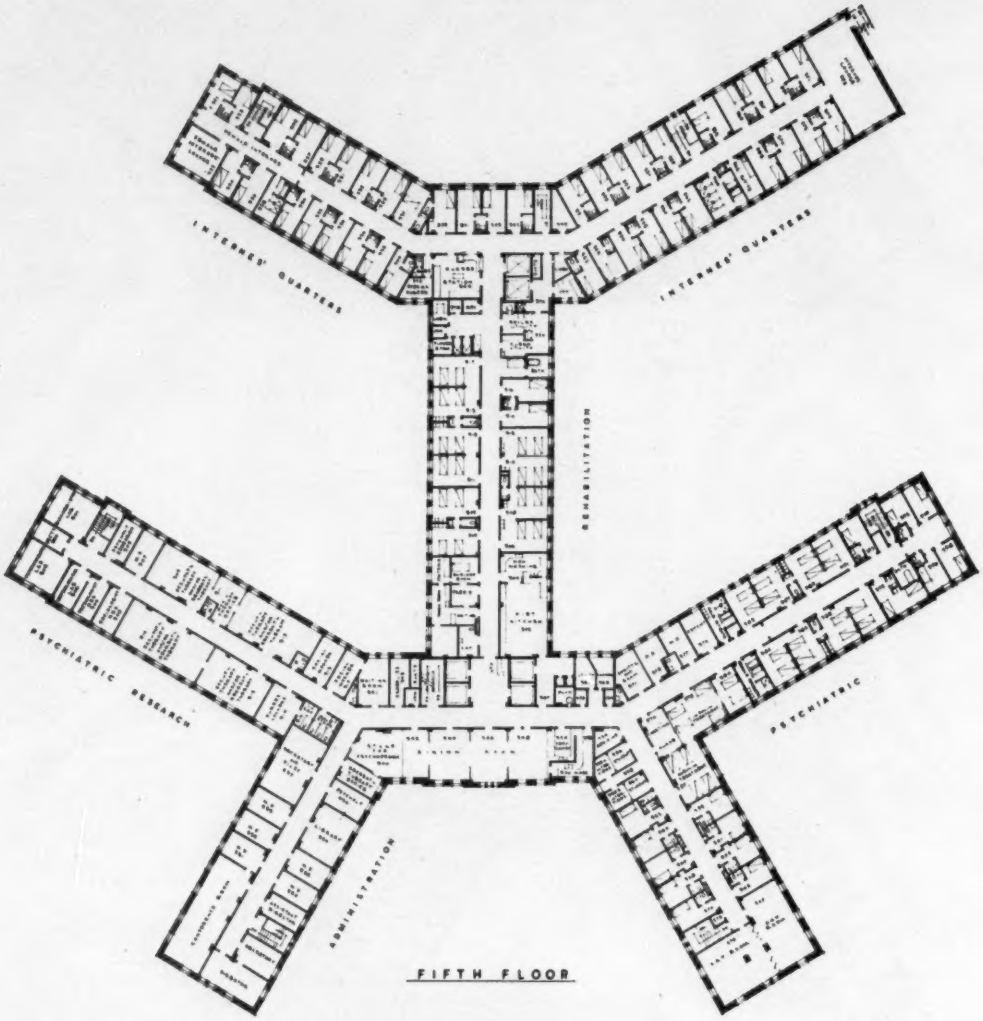




Architects: Webster and Gilbert, Saskatoon, Sask.

Associate Architects: Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto.

Consultant: Dr. Basil MacLean, New York City.



(Concluded from page 42)

oxygen storage tank and suction are available at every bedside.

Surgical patients are accommodated on the second floor throughout the various wings. This is the floor on which the operating rooms are situated. Medical patients are on the third floor and maternity patients and nurseries are on the fourth floor adjacent to the obstetrical suite. Fifty beds on both the medical and surgical floors will be assigned to D.V.A. patients. The number will vary as occasion demands. There is no hard and fast boundary between D.V.A. and other patients. The paediatric department is on the main floor of Wings A & B near the front entrance.

A well equipped department for the treatment of psychiatric patients occupies the fifth floor at the front of the hospital. This department is organized to give intensive treatment to a comparatively small number of patients. Rooms for various types of therapy occupy one wing.

A special cafeteria and dining room on this floor serves both psychiatric and rehabilitation patients.

Laundry Service

A laundry to serve the entire university is located behind the hospital and is connected with it by tunnel. The laundry is operated by hospital staff. All sewing and mending is done under the direction of the laundry manager who also controls all collection and distribution of linen. Stainless steel laundry chutes in each wing, with openings at each floor, lead to the basement where soiled linen will be collected and trucked through the tunnel to the laundry. It is lifted by an elevator to the mezzanine floor where sorting is done. It drops by gravity to the washers and is processed on the main floor.

Hospital maintenance shops are located on the ground floor of the laundry building.

Since construction on the hospital was started methods of treatment have changed and entirely new methods have been adopted. Alterations have been made to the building to keep pace with the times. No effort and expense have been spared to make the institution one of the most complete teaching hospitals in Canada.●

University Hospital stresses—

Rehabilitation Medicine

T. E. Hunt, M.D., F.R.C.P. (C),
Director,
Department of Rehabilitation Medicine,
University Hospital,
Saskatoon, Sask.

THE TERM "rehabilitation medicine" has been selected for use in this department, as it implies close association between medicine as a whole and that part of it which is referred to as "rehabilitation." With our modern concepts of treating the whole patient, it is obvious that our professional care must not cease with the writing of prescriptions or the removal of sutures, but should continue until the patients can satisfactorily maintain themselves in their own communities at some gainful occupation. This third and final phase of medicine is rehabilitation in its broadest sense and suggests that most patients may require some sort of rehabilitation. This rarely presents any problem in the case of the post-partum woman, or the child whose appendix has been removed, or the man who has had an acute tracheobronchitis. However, with the chronically ill, disabled, or handicapped, the processes of restoration become more difficult and time-consuming, and hence have necessitated the development of this newer branch of medical science.

Although reference has been made to the concept of rehabilitation as the third phase of medical care, it should not be considered a separate period of after-care. On the other hand, for best results rehabilitation must proceed hand-in-glove with its more recognized. associate phases of management, namely, prevention, diagnosis, and treatment. Indeed, one should think of rehabilitation as commencing with the first visit or admission of the patient. Thus, by having the facilities of rehabilitation medicine available at an early date for our patients much more effective patient care can be provided by all hospital departments.

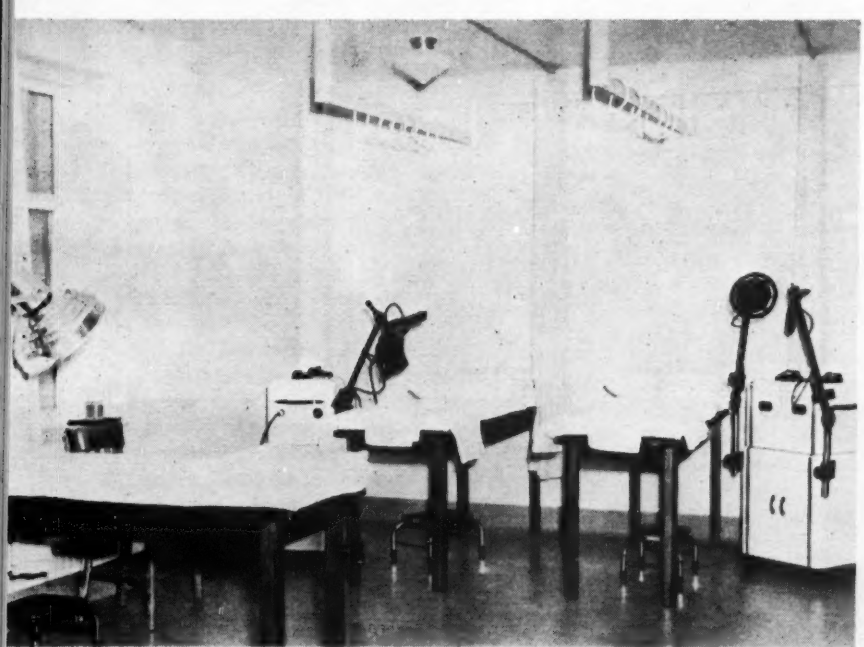
Many Services Involved

Total rehabilitation requires the collaboration of many services. The nurses on the rehabilitation ward, for example, are responsible for assisting in the supervision and instruction of patients in many self-care activities; and special instruction is being planned so that many of the other nursing instructors will become rehabilitation conscious, particularly with a view to "daily living activities." Thus it is to be hoped that on each service and ward valuable hospital time can be saved by teaching handicapped patients to get in and out of bed, on and off toilets and chairs, and so forth.

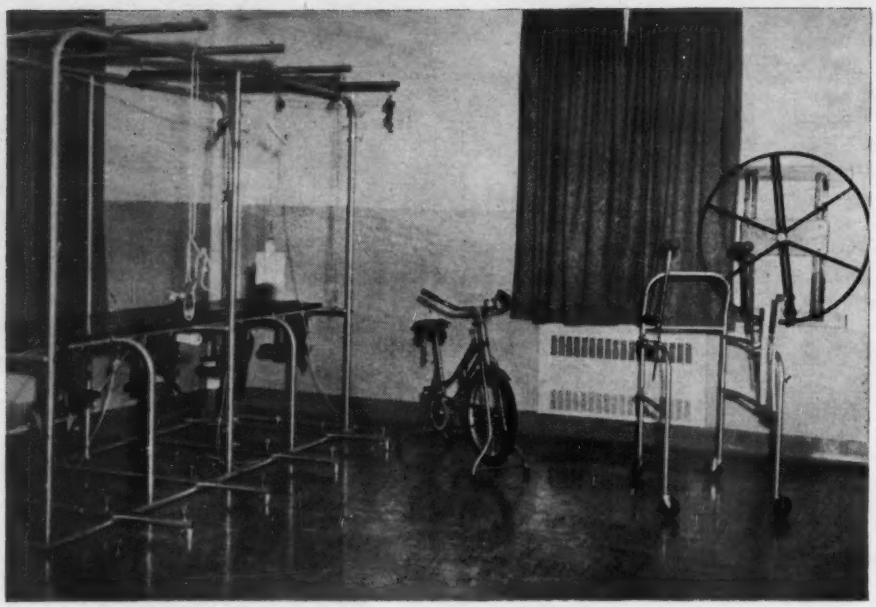
Similar collaboration with other departments within the hospital, such as social service, psychological medicine, and administration, is essential in the development of adequate rehabilitation services. This is being fostered at the University Hospital, as is association with a number of community services. These include the Vocational Training Centre, the Department of Health's Physical Restoration Centre, the Department of Social Welfare and Rehabilitation of the provincial government, and the special employment branch of the National Employment Service's local office.

Research and Teaching

In the field of clinical investigation, the department of rehabilitation medicine has much to contribute to the hospital as a whole, and to the medical college. Research in rehabilitation techniques and the development of self-help devices are an essential part of the unit. Many of the long-used physical modalities have not been tested through an adequate scientific approach, and studies in this field will be most helpful here and elsewhere. Again, the clinical applications of electromyography are still in their infancy stages, and much useful information is yet to come from this field of



Part of the physical therapy area. Note booms above the plinths for attachment of exercising equipment during therapy.



View of part of the remedial exercise area. Note the exerciser on the left. This relatively inexpensive apparatus has a wide variety of uses and can serve up to four patients at one time.

investigation, sponsored by the department.

From an educational point of view, the department is primarily concerned with teaching of the physical therapies and rehabilitation techniques to medical and nursing students. However, many more possibilities can be utilized with proper integration into almost all parts of the medical curriculum. Through their training and special interests, the medical staff of the department can bring the clinical approach to the students in the early years of the course in such subjects as neuroanatomy, anatomy of the musculoskeletal system, and in neurophysiology. In the senior years, correlation clinics or lectures with the other teaching departments will be of considerable benefit to the development of an overall training of the students. Plans are being made, too, for future post-graduate training courses, not only for those intending to specialize in rehabilitation but for practitioners, nurses, and physical therapists as well. Through such programs, we can look forward to having, eventually, adequate, province-wide facilities for rehabilitation.

The preceding paragraphs have described the general philosphy of rehabilitation and the roles which that service must fulfil in a modern teaching hospital. An effort has been made to indicate a concept of the department of rehabilitation medicine, not as an isolated unit giving an odd special treatment to an occasional patient from here and there, but rather as an integral part of the hospital as a whole, and an essential service for the proper care of all patients.

In the University Hospital, Saskatoon, this includes medical and therapeutic services, and care of patients on a special rehabilitation ward.

Medical Service

The medical services, which are provided by the medical members of the departmental staff, include consultations, assistance in treatment management to all services, supervision of the care of patients on the rehabilitation ward, electrodiagnosis, and prescription and supervision of *all* the physical therapies requested by the attending physicians and surgeons. The latter is considered a very important function of the medical staff for it permits adequate control of the department's activities. It also provides one of the essential links between departments, through the necessity for ward rounds on all services.

Therapeutic Staff

The therapeutic services provide the physical and occupational treatments requested, and, particularly, facilities for rehabilitation of persons with acute and chronic disabilities. The therapeutic staff will consist of six physiotherapists, one remedial gymnast, six occupational therapists, and a special rehabilitation therapist. The main duties of the latter are to instruct and supervise the carrying out of activities of daily living for rehabilitation cases and to co-ordinate other therapeutic procedures for these patients. A speech therapist is also being added to the staff in the near future.

Facilities

The facilities for these services are located on two floors of one wing of the hospital. The physiotherapy area on the ground floor includes an electrotherapy room, containing six treatment cubicles. Three of these have been provided with solid over-head booms above the plinths, to allow suspension exercises to be carried out after heating. Directly adjacent to the electrotherapy room is another large area, part of which is partitioned off for ultraviolet irradiation, the remainder being arranged for some of the activities of daily living programs. It includes a cot, several chairs of different types, a vanity-desk, and wall mirror. This room also doubles as a space for review of cases by the medical staff. At the end of the corridor, spanning the wing, is the exercise room, provided with the usual assortment of exercise and ambulation equipment.

The hydrotherapy area consists of two rooms, one for wax and whirlpool baths, and the other containing a large Hubbard tank.

For the most part, the equipment used is not unusual and is the same found in any good physiotherapy department. Two items in the exercise room deserve some comment, however. These are the universal exerciser and the "lowering boom." The exerciser is a multi-purpose unit obtained from England, and can accommodate four patients at once on arm and leg exercises. Back cases can be handled separately. This unit is designed for heavy resistance activities and is available at a much lower price than previous equipment used for similar purposes. The "boom" consists of a length of light-weight steel which spans the width of the room and can be lowered or elevated to the ceiling level as required. Sling suspension exercises can be carried out with it, and a roller on top allows for "breeches-buoy" type of support, to help with early ambulation. Our general-body-irradiation ultraviolet generator is also somewhat different, utilizing fluorescent-type ultraviolet tubes with reflectors. The advantage of this piece of equipment lies in the fact that the greater amount of radiations are in the high end of the spectrum (above 3100ª) with a lesser proportion of the lower erythema-producing rays being present.

The occupational therapy department is divided into two sections. An area consisting of two large well-lit rooms and an intervening office, for light to medium activities, is located on the fifth floor, almost adjoining the rehabilitation ward. The floor area of this clinical section totals 1,032 square feet. The heavy workshop is situated on the ground floor, along with the physiotherapy rooms, and provides an additional 688 square feet of clinic area. Practically all types of activities are provided, ranging from very light bed work to heavy carpentry and shovelling in the sand-box. A kitchen is also being incorporated to provide retraining facilities for disabled housewives.

Mention has been made previously of the close co-operation with other departments, and the occupational therapy program is an excellent example of this. Rehabilitation medicine provides this service for all departments, including that of psychological medicine. In return, the latter department has provided us with further much-needed space, and utilization of recreational activities, including quiet sedentary games, billiards, ping-pong, and shuffle-board.

The rehabilitation ward is a 22-bed unit occupying the fifth floor of the central wing of the hospital. Its special purpose is to provide hospital care and restoration facilities for all types of rehabilitation problems, including those of paraplegia, hemiplegia, cerebral palsy, poliomyelitis, rheumatic diseases, cardiopulmonary disease, and other types of chronic disability.

Patients are admitted to this ward, after evaluation of their rehabilitation needs, for an intensive restoration program, which, in general, is designed and co-ordinated to make them as self-sufficient as possible in their activities of daily living and, where feasible, ready to take their places in the community. Collaboration with social service, psychological medicine, the Social Welfare Department's retraining program, and the special employment branch of the National Employment Service is fostered, so that a total program can be initiated during the patient's hospital stay. Continuous contact is also maintained with the community, so that an eventual return to gainful occupation in home surroundings may be the final goal of the majority of those admitted for specialized care.

Rehabilitation is the responsibility of all good doctors, nurses, therapists, and every one employed in patient-care services.o

A corner of the occupational therapy suite.—Star Phoenix Photo.

The cafeteria. The windows command an excellent view of the Saskatchewan River.

University Hospital—

Dietary Facilities and Service

THE ENTIRE sixth floor of this imposing greystone structure is devoted to the main kitchen, formula room, cafeteria, and dining room. At the time of planning there was much discussion as to the location of the kitchen. Those of us who have worked in basements and eaten in poorly lighted dining rooms are delighted with the location on the sixth floor. A question often asked is "How do you manage to get supplies up to the main kitchen?"

Food supplies are checked and weighed at the receiving entrance on the ground floor. Non-perishables such as canned foods, cereal, et cetera, are placed in the main hospital stores and requisitioned daily. Meat for long-term storage may be held in a large walk-in deep freeze. Vegetables are taken to a vegetable room equipped with a walk-in refrigerator and a vegetable peeler. Vegetables are stored here; they are then peeled and delivered to the main kitchen as required. Any small meats, such as sausages or bacon, are taken directly to the butcher shop on the sixth floor.

The Main Kitchen

The main kitchen is light and spacious with cooking, baking, salad preparation and butchering areas. A separate area has been set aside for the preparation of special diet foods and nourishments.

The walls are a shade of creamy yellow cement enamel—a sprayed-paint finish with a hardness similar to porcelain. Floors are of red quarry tile.

The main cooking area is equipped with two three-deck steamers, two grill tops, two broilers, deep fat fryer, three steam jacketed kettles with 30-, 40- and 60-gallon capacities, and an 80-quart food mixer with adapters for 40-quart attachments. Ovens and ranges are electrically heated. Food is held in steam-heated cabinets. All counters and cupboards are of stainless steel with removable doors.

The pot-washing area is equipped with a triple-compartment sink. Each compartment is steam heated and has a separate control valve. Clean pots and pans are stored on galvanized slotted racks. The porter who washes the pots has a magnificent view of the Saskatchewan River.

The bakeshop is complete with a walk-in refrigerator. Stainless steel portable bins are used to store flour, sugar, cocoa, et cetera. Spices are at eye level in pound-size stainless steel boxes with hinged lids. Equipment consists of a triple-deck oven, a steam jacketed kettle, a stove, a 60-quart food mixer with adapters for 30-quart attachments, a bun proofer, and a bun divider. Pots and pans used in baking are washed in a stainless steel compartment sink.

The salad preparation area was planned with a long, low table at which staff may sit while chopping. Wooden chopping blocks are set into the table along either side and are removable for cleaning. Shredding, chopping and grating are done in a food chopper in this area.

The butchershop is equipped with an electrically operated meat saw and meat grinder. A meat tenderizer means that tough steaks are no longer a problem. A refrigerated fish box is available for storing fish. The large walk-in refrigerator has racks for hanging meat and movable racks for storage of cut meats.

The Formula Room

The formula room, in contrast to the rest of the kitchen, has cool green cement enamel walls. The area is divided into two distinctly separate units with an autoclave installed in the adjoining wall.

Electrically operated bottle brushes assist with cleaning soiled bottles before they are taken to the second room or "clean" area where formulae are prepared. All mixtures, except a few which are not stable to heat, are subjected to terminal sterilization of seven pounds pressure at 230°F.

Personnel

The dietary department is supervised by the qualified dietitians who are responsible for the planning, preparation, and serving of all foods to the patients and hospital staff.

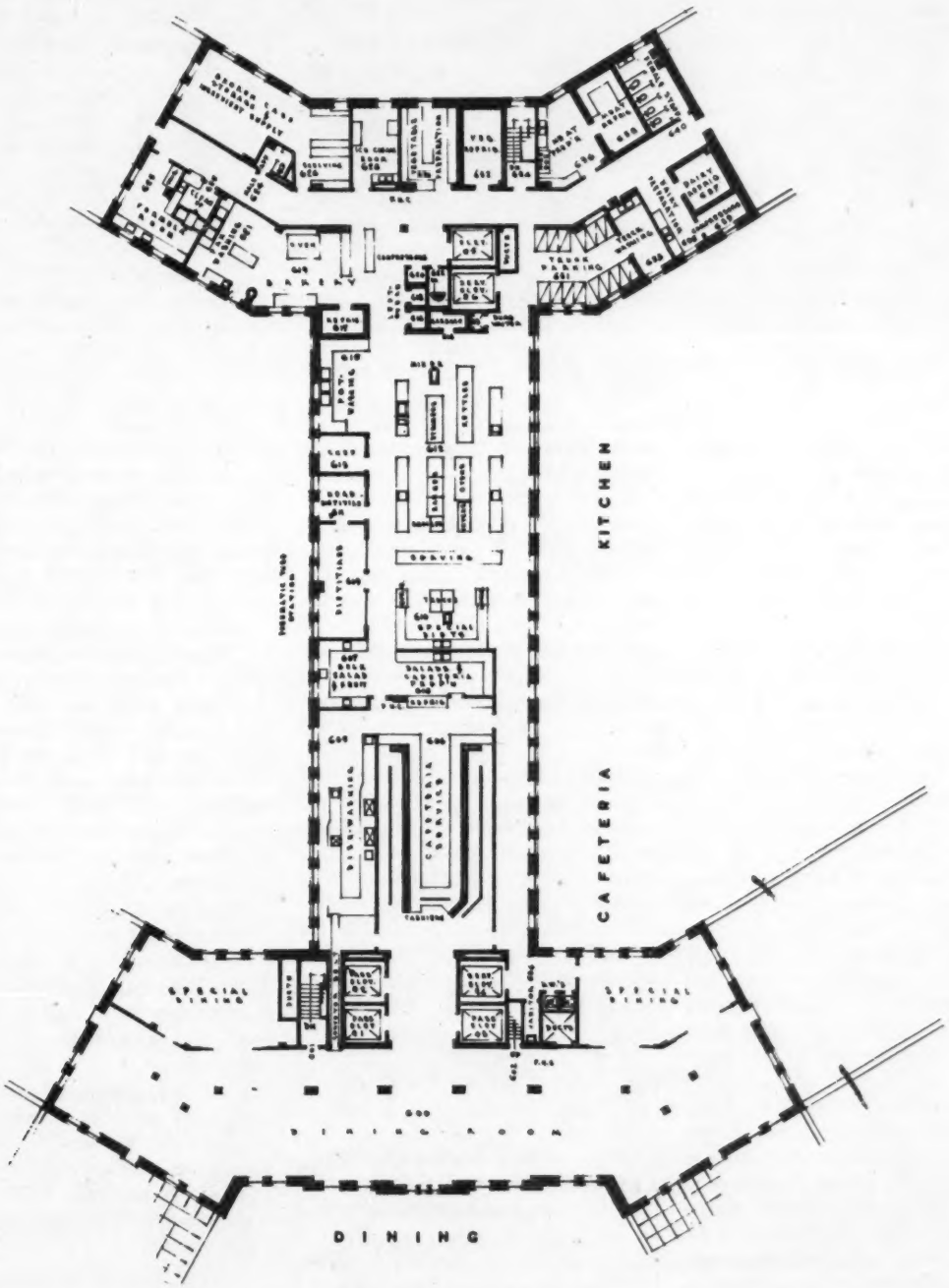
Charlotte Paxton,
Chief Dietitian,
University Hospital,
Saskatoon, Sask.

Other staff consists of a chef, trained cooks, a baker, and a cafeteria supervisor. Dietary aides, who are in specified categories according to their duties, assist with the serving of food, e.g., in the cafeteria and ward kitchens. These aides have not necessarily been chosen for their previous experience. Appearance, alertness, and general interest in serving attractive food were the major factors considered.

Each person on the dietary staff has been given both classroom and on-the-job instruction. Some of the topics discussed have been grooming, food handling, sanitation and interdepartmental relationships. Films, film strips, and demonstrations have been incorporated into this teaching program.

Menu Planning

A master menu is used in menu planning. A six weeks' rotating menu, into which seasonal foods are incorporated, is in use. To simplify preparation, food service is planned



Dietary Department on Sixth Floor

Spacious electric kitchens on the top floor are bright and airy. Note office for dietitians and chef in background.

to be suitable for staff who may be eating in the cafeteria or for the standard full, light, and soft diets used in the hospital. Variations in the menu are made to conform with dietary restrictions of individual patients. For example, an item such as deep-fried chicken croquettes on the menu would not be suitable for anyone on a Gastric No. 4 diet. The same chicken croquettes would be served in a baked form.

Private and public ward patients are allowed to choose from the same selective menus.

Selective Menus

Each patient on full, light, or therapeutic diet is given a selective menu from which to choose his meals for the following day. These menus are circulated on the breakfast trays and collected by dietary aides. Each menu is carefully checked by the staff dietitian who is assigned to the particular floor.

The first meal received by every patient carries with it a small brochure. This brochure contains a guide to marking the menus, a suggested menu, *Canada's Food Rules*, and a few pertinent points about the food nutrients. Each day's selective menu is on a different coloured paper in order that menus may be separated easily. Therapeutic selective menus are always printed on white paper.

A dietary clerk records the number of servings of each item ordered. It is her responsibility to order the food from the designated kitchen area. The gain in patient satisfaction and the reduction in food wastage has proved over a period of six months that this system more than compensates for the clerical time spent checking and counting the food marked on the individual menus.

Visiting of patients by the staff dietitians is part of the plan. Selective menus and the introductory brochures in no way substitute for the dietitian-patient contact. They do, however, have a teaching value to the patient.

Decentralized food service is the system used. There is a ward kitchen on each of the five floors. Each ward kitchen is equipped with a dishwashing machine, reach-in refrigerator, ice cream cabinet, refrigerated milk dispenser, hot water and coffee urn battery, two four-slice toasters, and a hot plate. Steam-heated cabinets are used for dish and tea-pot storage.

Dishes are of highly glazed, vitrified china which is attractive with its white background and maroon border. Disposable dishes are used on trays for isolation wards. Yellow plastic dishes are used in the snack bar and on the paediatrics ward. Tea-pots are stainless steel with heat-resistant handles. Plastic tumblers of five- and ten-ounce sizes are used throughout the hospital.

Silver-plated cutlery is immersed in a steam-heated silver-dip sink in a solution containing a wetting agent. This eliminates towelling. Periodic cleaning consists of dipping the silverware into a solution of tri-sodium phosphate.

Food is transported from the main kitchen, by means of a service elevator, to the ward kitchens in electrically heated food wagons which are thermostatically controlled. Cold food is transported to the ward kitchens by dumb-waiters.

"Later" serving hours, more simi-

(Concluded on page 68)

Food Service

sponsored by the

Canadian Dietetic Association

University Hospital—

Pharmaceutical Services

J. L. Summers,
Director of Pharmaceutical Services*, University Hospital, Saskatoon, Sask.

IN HIS monumental work on hospital administration, Dr. MacEachern states: "The pharmacy is the most extensively used of the therapeutic facilities of the hospital." The recent development of a variety of new and therapeutically effective medicinal agents has assured the continuation of this situation for some time to come. To provide for this vital facility, a Department of Pharmaceutical Services has been established at the University Hospital and it is charged with the responsibility of providing full pharmaceutical and central supply service. Though not entirely new, the grouping of pharmacy and central supply service within the structure of a single department is a relatively recent procedure.

Full pharmaceutical service in a teaching hospital involves a number of functions, the more important of which are dispensing, manufacturing, education, and departmental administration. To provide this service, the facilities of the department consist of a dispensary, a manufacturing laboratory, and a stores area. The generous provision of space by the administration has made the physical organization of the department on this basis a relatively simple task.

In hospital pharmacy, as in retail pharmacy, dispensing is the primary professional responsibility of the pharmacist. The term "dispensing" in a hospital is generally used to include those activities directly concerned with the provision of drugs used in the treatment and care of the sick. This involves filling individual prescriptions for patients, the issue and replenishment of ward stocks for the nursing stations and the compounding and delivery of special preparations to the operating theatre and delivery suite. Dispensing also includes the provision of diagnostic and analytical agents to the departments of radiology and pathology.

The dispensary of the University Hospital is contained within an area of approximately 800 square feet, and is organized to facilitate the performance of the various dispensing activities. The centre of the dispensary is occupied by two identical dispensing units which are immediately backed by a 16-foot unit of "Schwartz" type cabinets containing the bulk of the stock dispensed on individual prescriptions. This arrangement forms a compact prescription area with frequently prescribed items within easy reach of the dispensers. A section of the dispensary has been allocated and equipped for compounding preparations requiring special technical treatment such as emulsions, suspensions, and ointments.

**The author is also Associate Professor of Pharmacy, University of Saskatchewan.*

Schwartz type cabinets place a wide range of medications within easy reach of the pharmacists in the dispensing area.

A portion of the dispensary is arranged to facilitate the replenishment of ward stocks and to handle bulk quantities of drugs and chemicals ordered by other departments. A large work table is provided for assembling and filling the ward drug boxes. It is also used as a working surface for prepackaging medications for ward stocks into standard units and for other bulk-breaking operations.

A clean-up area is situated behind the "Schwartz" cabinets which places the dishwashing operations out of the sight of the public. This somewhat secluded section also serves as a receiving area for stock brought in from stores.

Distribution

A routine system for receiving prescriptions and requisitions and for delivering drugs has been developed with the object of sparing the nurse the necessity of coming to the pharmacy. The development of such a routine has been made possible by the installation of the pneumatic tube system throughout the hospital. Prescriptions and special requisitions are sent to the pharmacy by pneumatic tube and most of the finished prescriptions go back the same way. The tubes will accommodate containers up to the size of an eight-ounce bottle, while those which are too large for the pneumatic tube are delivered by dumb-waiter or porter.

Ward stocks are handled in the usual manner. Ward baskets and requisitions are picked up first thing in the morning and are filled and delivered as soon as possible. The prepackaging of ward stocks speeds up the filling of requisitions. Penicillin and streptomycin are delivered to the wards twice a day by a pharmacy assistant. This ensures nursing units of an adequate supply of these antibiotics and prevents the accumulation of excess stocks on the wards.

Manufacturing

Manufacturing is an exceedingly interesting phase of hospital pharmacy. It is planned to conduct a fairly comprehensive manufacturing program on a pilot plant scale.

The manufacturing laboratory occupies a space of approximately 30 by 30 square feet and has been provided with equipment for the production of tablets, ointments, powders, and a wide variety of liquid preparations. Besides the economic aspects of these activities, such a program offers an excellent educational opportunity to students in hospital and industrial pharmacy.

Equipment for the preparation of large and small volume parenteral solutions is located in a special solutions room in the central supply area. The production and control of these solutions will be the responsibility of the pharmacist in charge of manufacturing. The system presently installed for the manufacture of solutions is basically the "Fenwal" system modified by the addition of constant-recording purity meters. Surgical fluids used throughout the hospital for purposes other than intravenous injection are also prepared with this equipment. The bulk of these fluids consists of sterile water and sterile saline for use in the operating theatres and delivery rooms.

Control

The proper storage and control of bulk stocks of drugs, chemicals, containers, and the "thousand and one" assorted pieces of equipment associated with pharmacy, though not quite so inspiring as dispensing or manufacturing, is a most important administrative function of the department. This activity has not been overlooked and the department has been provided with an adequate and well-appointed storage room directly below the pharmacy with ready access to elevator service.

The department is responsible for the purchasing and accounting of all pharmaceutical preparations, drugs, chemicals, oxygen and anaesthetic gases. A complete purchase record and perpetual inventory at stockroom level is kept for these items on a cardex file system. Drug charges to individual patients are submitted daily to the business office and a daily summary of the numbers, type, and value of all drug disbursements from the pharmacy is prepared for the director of the department. These daily summaries are condensed into a monthly financial report for the business office and the administrative officers of the hospital.

The professional policies of the department are formulated by the Pharmacy Committee which consists of the executive director of the hospital, representatives of the medical staff and the director of the department. The assistant medical director also attends meetings of this committee. Matters of policy are submitted to the Medical Advisory Committee for their approval. The Pharmacy Committee has proven to be a tower of strength to the department. The suggestions and assistance of its members have been invaluable and their interest and concern in the proper utilization of the facilities of the department has been nothing short of inspirational to the whole pharmacy staff. Through the efforts of this committee the first draft of the hospital formulary is now available.

With these facilities at our disposal it should be possible to provide the University Hospital with a first-class pharmaceutical service. It should also be possible to provide the College of Pharmacy with a unique educational opportunity.

Education

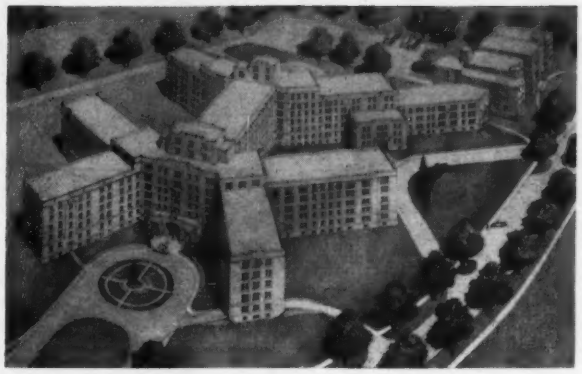
The most obvious role of the University Hospital in pharmaceutical education is the training of hospital pharmacists. It is planned to offer training programs in hospital pharmacy at both graduate and undergraduate levels.

Because of the organization of the academic program of the College of Pharmacy, University of Saskatchewan, it is possible for students to specialize in some branch of pharmacy in their final year. For the past seven years a half-class in hospital pharmacy has been offered in the final year of the course. This has been, of necessity, a course of lectures on hospital organization and basic administrative principles of hospital pharmacy. This year for the first time the college will offer a companion half-class in hospital pharmacy practice to a limited number of students. This course will consist of six to eight hours laboratory work and conferences per week. Students will be assigned laboratory periods in the various sections of the pharmacy to ensure their participation in as many hospital pharmacy activities as possible.

The object of the undergraduate program is not to turn out a qualified hospital pharmacist. This would be asking too much of a half-class. It is felt that such training as we will be able to provide in this short period will produce a student who has some understanding of the fundamental activities of pharmacy as it is practised in hospitals. On completion of the undergraduate course, it is hoped that some of the students will be interested in further preparation and study in the field of hospital pharmacy.

Plans are now being made for an

(continued on page 108)



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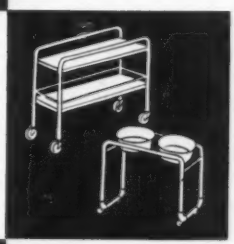
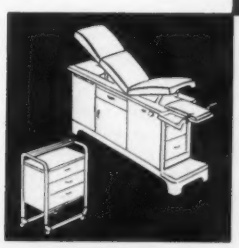
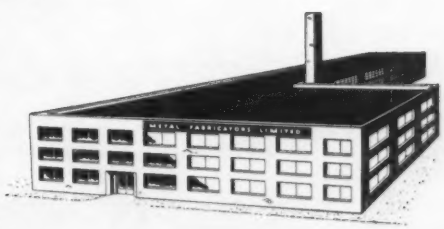


Dressing Carriages and Double Solution Stands

Sponge Racks, Pail Dollies and Instrument Tables



Examining Tables and Anaesthetists' Tables



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University Hospital—

Mechanizing Business Office Procedures

E. L. Casey, M.H.A.,
Chief Accountant,
University Hospital,
Saskatoon, Sask.

THE BUSINESS office is located in a central portion of the main floor near the main entrance, administrative offices, and admitting. It has a total area of 1,074 square feet. The vault, cashier's cage, and bookkeeping machines are located at one end, with the offices of the chief accountant and assistant accountant at the other.

The chief accountant is in charge of admitting, switchboard, and information but this article will be restricted to the accounting phase of the business office. The accounting system is based on *The Canadian Hospital Accounting Manual* (CHAM) with changes only to meet special circumstances caused by the Saskatchewan Hospital Services Plan (SHSP) or situations peculiar to this hospital.

The equipment of the business office consists of the usual number of desks, chairs, typewriters and adding machines. We have two bookkeeping machines. One is used for accounts receivable and the other is used for payroll, accounts payable and general ledger. The cashier's cage is equipped with a nine-total remittance control machine.

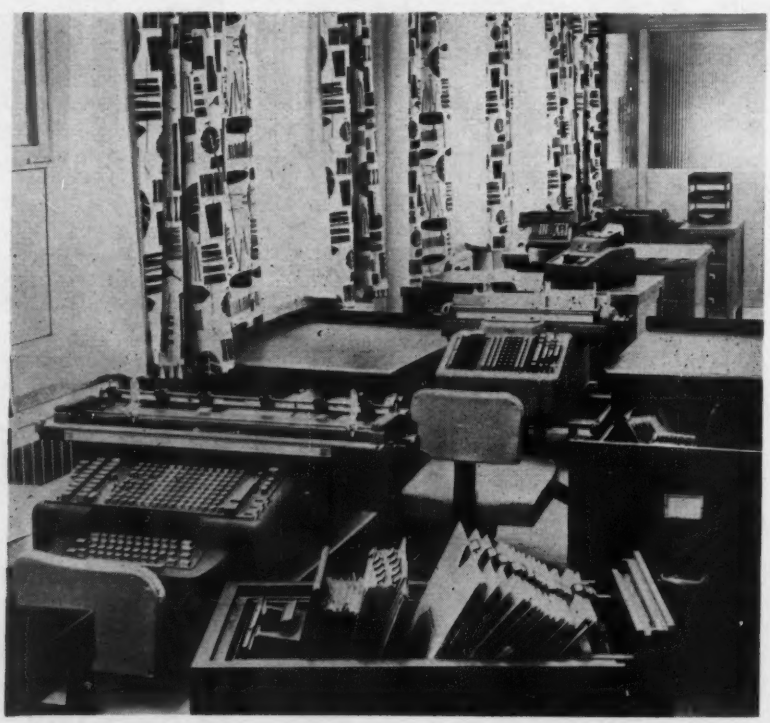
Accounts Receivable

The recording of accounts receivable in Saskatchewan is not as much of a problem as in hospitals in some of the other provinces, because we work on an "all inclusive" rate. There are extra charges only for services which are not benefits under SHSP. These extra charges include private and semi-private rooms and certain special drugs. We find that under this system it is not necessary to post the room rent daily. We post room rent only on discharge, except for the month end when all posting is brought up to date. The only postings that are done on a daily basis are cash receipts on patients accounts, charges to in-patients for special drugs and charges to out-patients.

One factor which complicates our handling of accounts receivable is the method of payment used by SHSP. They set rates on a cost basis and calculate them in terms of a per diem rate. For purposes of illustration, we will assume that their per diem rate is $12.00. Of the per diem rate, $10.25 is paid to the hospital in 24 equal, semi-monthly payments. The balance of $1.75 per patient day is paid as patients are discharged. The semi-monthly payment is calculated on an estimated number of SHSP patient days and remains the same even though the estimated days may not be realized or may be exceeded. Our monthly revenue from SHSP, therefore, consists of two semi-monthly payments plus $1.75 for each SHSP patient day, and it is this amount of revenue which must be set up in our books. This means that our ledger card must show revenue of $1.75 per patient day from SHSP but this amount cannot show on the patient's statement as it would tend to confuse him. This difficulty was overcome by recording SHSP receivables in a separate column on the ledger card without having it show on the statement or add into the balance. This can be quite easily done because our accounts receivable are posted on a side-by-side operation and the ledger card does not necessarily show the same information as the statement, although the balance must be the same. Payments by SHSP are not posted on the machine but are indicated by a paid date stamp.

Charges for special drugs also posed

(Continued on page 60)

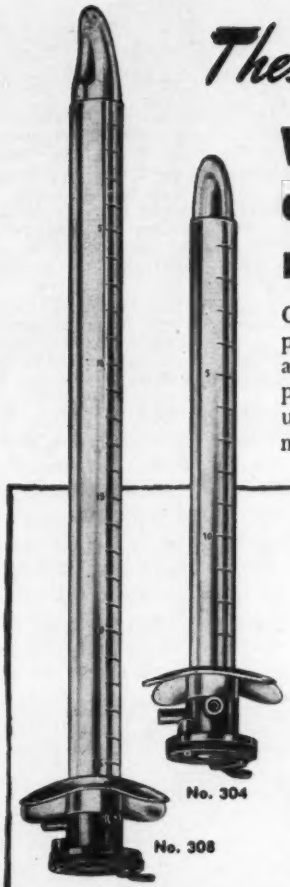


View of one half of the business office showing bookkeeping machines and posting trays.

These features of

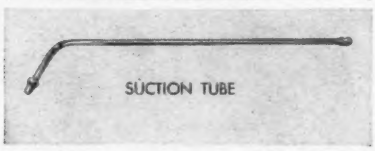
WELCH ALLYN SIGMOIDOSCOPES and PROCTOSCOPES make rectal examination easier

Cancer frequency in the sigmoid and rectum and the presence of possibly precancerous adenomas in this area dictate the importance of *complete* rectal examination as part of every general physical examination. Sigmoidoscopy is greatly facilitated by the use of modern Welch Allyn distally-illuminated rectal instruments with their many highly practical features.



FOUR SIZES: Regular sizes 25cm. length x 21mm. diameter and 15cm. length x 21mm. diameter. Infant sizes 25cm. length x 15mm. diameter and 14cm. length x 15mm. diameter. Longer lengths on special order.

No. 308-A sigmoidoscope has built-in smoke removal tube, a practical feature which preserves clear vision during cauterization.



No. 301 suction tube is a practical accessory for removal of seepage and fecal matter during examination or treatment.

On all Welch Allyn distally illuminated proctoscopes and sigmoidoscopes the obturator can be removed as shown, without touching soiled obturator tip.

AVAILABLE SINGLY OR IN SETS: This complete rectal set (No. 318) is one of several which your Welch Allyn dealer will be glad to show you. Contains anoscope, biopsy punch, probe and hook, battery handle and cord, suction tube, in addition to sigmoidoscope with built-in smoke removal tube and two proctoscopes.

ATTACHABLE HANDLE

No. 303 handle attaches firmly and quickly to instrument to aid in passage and manipulation. *(Must be ordered separately—not included in sets.)*

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(continued from page 58)

some difficulty because in submitting accounts to SHSP it is necessary to show the name of the drug being charged for. Since it would be time-consuming to refer back to the original charges each time an account was being submitted, we have assigned all non-benefit drugs with a numerical code. The appropriate code number is posted to the ledger card with each special drug charge. When SHSP accounts are made up, the code numbers are easily translated into the drug names.

Another item that is different in Saskatchewan is the SHSP 30-day report. This is a report that must be completed by the attending physician on all SHSP patients who have been in the hospital for 30 days. The only business office responsibility in connection with this report is to see that it is completed. At the present time this is accomplished by going through the in-patient file daily and picking out the SHSP accounts which are 30 days old. We hope in the future to set up a system of tabs so that by glancing at the file we can pick out 30-day accounts. We also hope to expand the use of these tabs to our collection follow-up.

Since more than 90 per cent of the population in Saskatchewan have hospital plan coverage, we do not have as many collection problems as some other parts of the country. Deposits are required from patients requesting private or semi-private rooms, as well as non-SHSP patients. The main problem is with non-SHSP patients who are considered emergencies. These patients must be cared for and cannot be turned away but often present a considerable collection problem.

Accounts payable and General Ledger

Accounts payable and general ledger are posted in one operation on the general-purpose bookkeeping machine. We use the unit method of distribution. This means that all expenditure items are automatically posted to the general ledger at the same time as they are posted to the accounts payable voucher. The upper portion of the voucher cheque is used as the accounts payable voucher.

One feature of our method of handling accounts payable is that we have the immediate pay option. While posting the accounts payable, if there is one that should be paid immediately it can be done without changing the bar or backing sheets on the machine. This is done by using the right-hand side of the carriage as a cheque register.

Non-expenditure items which affect the general ledger, such as revenue and cash receipts, are summarized and posted by using a journal entry.

The University Hospital pays all its accounts on an invoice basis. This eliminates the duplicate payments which so often occur when payments are made on the basis of statements.

The purchasing office is responsible for approving invoices and checking extensions. The business office codes the invoices, posts them, and makes the payments.

The only procedure which may be of special interest is our method of handling the three per cent Saskatchewan sales tax. This tax is payable to the provincial government on most items purchased outside the province. We code this tax to the appropriate expense on our invoice. When the invoice is posted, the sales tax payable is set up and the expense account increased by the same amount. This sales tax does not show on the voucher and does not affect the amount of the voucher. Sales tax on purchases inside the province is paid direct to the vendor and does not cause any problem.

Payroll

All employees record their time by punching one of two time clocks in the hospital. The time clocks are the fully automatic, 2400-hour, direct-subtraction type. They are conveniently located, one at the personnel entrance on the ground floor and one at a central location on the main floor. The time card for each employee is placed at the clock most convenient to him.

Each time card is for a 14-day period with seven days on each side of the card. The time card is drawn up so that the hour, the bi-weekly pay, and the deductions are calculated right on the card. The time card is then used as posting media in preparing the payroll.

As mentioned above, the payroll is on a bi-weekly basis. The pay periods end every second Sunday and we pay the following Friday. This system of payment has advantages over the monthly or semi-monthly pay period, and I understand it is becoming more popular in industry.

The following are among the advantages of a bi-weekly pay period:

(1) The time between pay periods is shorter.
(2) Each pay period is the same.
(3) The period between the Sunday close-off and the Friday pay-day gives ample time to make up the payroll.
(4) Unauthorized time off, unearned sick leave, or leave of absence are easily adjusted because the payroll is not prepared until after the pay period has ended.
(5) All pay-days fall on a Friday on which day the local banks are open until 6:00 P.M. This gives the majority of employees an opportunity to cash their cheques on the day they are received.

The payroll is prepared on the general-purpose bookkeeping machine. In one operation it prepares the payroll cheque with stub, the employee's earning record and the payroll record which is also the cheque register. The cheque stub shows the deductions from earnings, as well as the hours and gross pay for regular time, overtime, sicktime and vacations. The employee earning record shows the gross pay, deductions, and year-to-date totals for gross pay and income tax. These totals facilitate the preparation of T4 forms at the year end.

With an expected total of 1,000 employees including student nurses, it is anticipated that we will issue in excess of 20,000 payroll cheques per year. Since sorting such a large volume of cheques into numerical order creates a problem, we have attempted to simplify this by going in for the unisort method. The cheques are punched along the upper right hand corner by journal page number. When the cheques come back from the bank, they are sorted into groups of about 40 by using a sorting needle. It is then only a matter of sorting the groups of forty into numerical order.

The payroll office is located on the ground floor adjacent to the personnel office. It is located here for two reasons. The first is that we expect to be short of space in our main business office, and the second is that because of the close relationship between payroll and personnel it was felt advisable to have them located in the same area.

The payroll staff consists of one full-time person. It is expected that when the hospital is in full operation, one other person will be assigned to the payroll office for the week during which the payroll is prepared. The actual running of the payroll on the

(concluded on page 102)

Good health for

Non-profit prepayment health plans

Joseph A. MacMillan, M.D.,
Executive Medical Director,
Maritime Hospital Service Association,
Charlottetown, P.E.I.

MY OLD pathology professor at McGill, Dr. Horst Oertel, used to speak rather forcibly of the continual flux and the morphological fluidity which characterized human cells and human tissues. He went to great lengths to impress upon his students the basic fundamental concept that life, as we know it, consists of an unending and ceaseless alteration of the relations between an organism and its environment, which relations are governed and circumscribed by certain immutable regulations emanating from both natural and divine law.

I know of nothing which has more amply demonstrated the morphological fluidity of living things than the continuous flux which has characterized prepaid health care since I first became interested in it about twenty years ago. These changes certainly can be characterized as alterations between the organism, prepaid health, and its environment, between the agencies attempting to pay for the health care provided both in the hospital and medical field, and the patient subscriber who is footing the bill. These changed relations have now been further complicated by the entry into the field, to a very large measure, of the employer, who so often today pays part or all of the bill for the coverage provided by the prepaid agency.

However, looking back over the years, with particular reference to the ten odd years which we have in the way of experience in Maritime Hospital Service Association, I am more strongly convinced than ever that there are some basic fundamental principles which originate from the inalienable and immutable rights of all parties concerned which must necessarily govern the pattern which prepaid health care must take in the future.

From an address at the Blue Cross Session of the Maritime Hospital Association convention held in Charlottetown, P.E.I. in June. Speakers on the same panel were Joseph A. MacDougall, M.D., Chairman of the Board, Maritime Hospital Service Association; Rev. Mother Ignatius; J. Arthur Clark, M.D.; and W. Russell Fiske, members of the Board of Trustees... The session was under the chairmanship of J. A. Likely, Charlottetown, P.E.I.

Principles

I would like to take this opportunity to outline once more the basic principles which I have always felt should govern our deliberations in this field, and secondly, perhaps, try to solve some of the newer problems in the light of these same principles which the originators of our Plan used to guide them in the beginning.

The first principle of health care is that the human individual who is ill, or who needs preventive care to keep him from becoming ill, has by his very nature the right, both in justice and charity, to the services of his fellow man who is able to care for him, to guide him, or to cure him. It follows then, that hospitals, doctors, nurses, technicians, public health departments, government health and welfare agencies, all have their reason of being tied up in the inherent worth of the individual. Nothing which degrades him, lessens his care, which tends to the advantage of any second or third party at the expense of the individual can be right or just, equitable or adequate in the field of health care.

The second principle of the golden rule in the field of health care follows directly from the first. This is, since the individual, by reason of his being a creature of God, has the right to the best of health care from all of us who are in the health field, then the complimentary obligation which falls on our shoulders is to be qualified, worthy and willing to administer to our brother's needs. But this relationship of right on the part of the individual, and obligation on the part of us all who are dedicating our lives to the care of the sick, is not a one-sided relationship. Hospital personnel, nurses, doctors, research workers, each in their own fields, are persons whose efforts are worthy of reward. If the labourer is worthy of his hire, then the laws of justice and charity apply quite as forcibly to maintain the principle that hospital, medical, and other personnel have a right to an adequate return for their efforts, commensurate with their knowledge, their skill, the length of time spent in carrying out their vocations, and especially to the responsibility which they take in caring for the sick. I am afraid that at times we professional people have failed ourselves in bringing forth to the public the basic fact that the requirements of our calling are of a very special nature, that they require time-consuming, earnest and assiduous devotion to study for many years. We should perhaps point out more forcibly the long years of sacrifice, hard work and tedious training which are the lot of all professional people who would become adequately trained in the health field. And without fear of dropping from the professional field into the materialistic field of economics, I think it only fair to mention that in no field of human endeavour do the demands for service come at more inopportune times, with more insistence and persistence, without regard for hours, for duration or continuation of duty, than in the care and ministration to the sick. I believe we owe it to ourselves to express fearlessly at all times our claims in justice to a remuneration which is not exaggerated or out of proportion. From this second principle, therefore, it becomes obvious that all prepaid health care plans must necessarily operate with justice to those receiving the service, but in equal justice, must reward those who are providing health care with a return commensurate with the dignity, responsibility and demands of the health professions.

"Thou Shalt Not . . ."

The third principle (and perhaps the least understood and certainly the least appreciated) which should govern the relationship between the sick,

(Continued on page 64)

OF INTEREST TO YOUR ENTIRE STAFF...

THE LEDERLE FILM LIBRARY

The Lederle Film Library comprises a number of professional-quality, 16 mm. motion pictures and 35 mm. slide films on subjects of interest to doctors, nurses, pharmacists, and other hospital personnel. Many of these films are in color, and some are available with both color and sound.

Films are loaned without charge to accredited medical institutions and organizations. Booking requests should be made at least three weeks before the showing date.

To aid you in using the Library, Lederle has prepared a brochure which lists the films available and gives a brief description of each. Ask the Lederle Representative to get you a copy, or write:

FILM LIBRARY
LEDERLE LABORATORIES DIVISION
NORTH AMERICAN Cyanamid LIMITED
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Lederle

Prepayment Health Plans

(continued from page 62)

those caring for the sick, and those in the prepayment health field, is that of personal responsibility. You and I are not only bound by the law of justice and charity and encumbered, if you will, with the obligation of caring for our fellow man, but we are also bound in conscience to take nothing which does not belong to us. "Thou shalt not steal" is very easy and simple to understand. But, "Thou shalt not cheat", "Thou shalt not over-charge", "Thou shalt not bill for services not rendered", "Thou shalt not ask for services when they are not needed", and especially "Thou shalt not take from government, insurance or other third party agencies anything that is not lawfully thine" fail in their implications to impress many individuals in health care. Moral responsibility for subscribers, hospitals, and doctors, human integrity, honesty, and a personal responsibility for the success of prepayment are in direct proportion to the inherent moral fibre of the individual. I believe it is the duty of each and every one of us who are perhaps better acquainted with the great need for moral integrity and personal responsibility in the health field, to try honestly, forcefully, and even with personal sacrifice, to impress this great lesson on those who do not understand this problem. To evade our own responsibility by saying that someone else will do it does not appear to me a satisfactory reason for remissness in our duties.

During the past ten years, Maritime Hospital Service Association, which was conceived and brought forth in great labour by the immature Maritime Hospital Association, is approaching its maturity. The trials and tribulations of childhood and the lessons which we have learned would appear to be at the matriculation stage. We are about to embark on a newer and a wider field of endeavour. In 1943, the Maritime Hospital Association represented 52 member hospitals. Today there are 92 member hospitals. In 1953 member hospitals had a total capacity of 3,987 beds. In 1955 the capacity is 6,505 beds. In 1943 Blue Cross was charged an average of $3.86 per patient day. In 1955 the average day's cost is $10.00. New facilities have been added in most hospitals which were unheard of at the time we started; and for this your patients are grateful, the public is thankful. Our plan has participated in this over-all improvement and expansion of health service to the extent that during our years of operation we have helped patients pay hospital bills totalling $20,482,006.

During the past five years, our plan had the opportunity of participating with the medical men of the Maritime provinces in helping to provide a medical prepayment plan. This four-way association between the patient, doctor, hospital and prepayment plan, although charged with many interlocking problems, nevertheless has been a happy association. It is now, I believe, beginning to bear fruit in a co-operation which we have hitherto never known in this area. A new alertness seems to have arrived in the minds of all of us, an awareness not only of our own obligations but of the tremendous contribution made by the other fellow, an awareness which has been a stimulus to all of us to put greater effort into the success of our common undertaking. We have found together that our basic problem, that of increasing costs, is not altogether caused by the greediness of the patient for service, nor the avarice of the hospital for monetary return, nor even the greed of the doctor for gain, but by an increasing entanglement of economic factors over which none of us has control. These we must face in this new era of material prosperity and a higher standard of living which our people are now happily able to provide for themselves.

With research, medicine, surgery, hospitalization, and nursing gaining in their capacity by leaps and bounds and able to provide for the Canadian people health care beyond our fondest expectations, we must revise and bring up to date our methods and our thinking in order to prepay these services for the public, just as we did in the beginning of our plan. If we were right in inaugurating prepayment with the principles which I enumerated earlier, then it is a challenge to our ingenuity to make this plan work. Prepaid health care should be promoted as a positive idea, a part of our way of life inaugurated for the common good. I am personally strongly opposed to the teaching that prepaid voluntary insurance should be accepted to prevent government health insurance or state medicine. Not only is this type of motivation inadequate, unreasonable and defeatist in nature, but to me it has no place in the thinking of a strong, virile and courageous Canadian people. We should ask our government to provide for us only those services and benefits which we ourselves are incapable of providing. We should demand government health insurance only if we, the people, are willing to admit defeat in this challenging, exciting and dramatic field

(continued on page 120)

Charlotte Tassé Honoured

Recipient of the Canadian Mental Health Association award (province of Quebec) for 1955, Charlotte Tassé is shown here with Dr. Jonathan C. Meakins (right), President of the Canadian Mental Health Association, and (left) Air Vice-Marshall Adelard Raymond, President of the Quebec Division.

Miss Tassé is president of l'Institut Albert Prévost, a neuro-psychiatric clinic in Cartierville, P.Q. where she established the first school for the training of practical nurses in that province. She was later elected president of the Commission for Practical Nurses. In 1953 she opened a post-graduate course in psychiatric nursing at l'Institut Albert Prévost. For the past 28 years, Miss Tassé has been editor of the monthly publication *La Garde Malade*.


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Rapport à l'Assemblée Biennale
de l'Association des Hôpitaux du Canada

Comité de Comptabilité et de Statistique

Walter W. B. Dick,
Moncton, N.B.

C'EST pour moi un privilège de vous présenter un rapport traitant des activités comptables dans les Hôpitaux Canadiens. Je réalise bien l'importance de ma tâche car dans l'opinion des membres du Comité de Comptabilité et de Statistique, il n'y a rien de plus vital que la comptabilité pour comprendre et contrôler les finances d'un hôpital.

Ce point de vue fut partagé par le Dr. O. C. Trainor, alors qu'il disait dans son discours présidentiel à la dernière assemblée biennale: "Je crois qu'il n'y a pas d'exagération à dire qu'aucune initiative du Conseil depuis sa création est appelé à avoir un aussi bon effet que le Manuel de Comptabilité de l'Association".

Plus récemment, le docteur G. D. W. Cameron, sous-ministre de la Santé au gouvernement fédéral déclarait en traitant de l'efficience administrative au 30ème congrès annuel de l'Association des Hôpitaux de l'Ontario, dont le thème général était: "efficacité avec économie": "C'est avec intérêt que nous avons remarqué depuis quelques années que le conseil d'administration des hôpitaux accordent une importance toujours plus grande aux procédures administratives dans leur institution. Cette façon de voir a conduit les hôpitaux à embaucher des administrateurs spécialement qualifiés, et à accepter d'une façon générale la standardisation des rapports et des procédures comptables".

Votre comité a également l'impression que la mention "George Findlay Stephens Memorial Award" décernée durant cette assemblée biennale, à M. Percy Ward, un ancien président de ce comité, est une autre preuve de l'importance que nous accordons au rôle que la comptabilité joue dans la vie économique de l'hopital. Permettez-moi de mentionner ici la contribution sans égale de M. Ward au travail de ce comité et en particulier à la comptabilité hospitalière. De plus, c'est un privilège pour moi de présenter ce rapport parce qu'il est un témoignage du progres passé aussi bien qu'une assurance pour l'avenir en ce qui a trait à un système de comptabilité uniforme pour tous les hôpitaux du Canada.

Avant de vous donner les détails de ce que votre comité a fait et de ses projets d'avenir, puis-je me permettre de signaler combien nous sommes reconnaissants de la coopération constante que nous avons reçue des directeurs et des membres de l'Association des Hôpitaux du Canada, de nos gouvernements à tous les nivaux et du conseil d'administration des divers hôpitaux. Avec de tels appuis, votre comité ne peut s'empêcher d'être enthousiaste pour l'avenir et de compter que les prévisions du Docteur Trainor dont il est fait mention précédemment se réaliseront.

Pour donner suite à la résolution du Conseil des Directeurs du 30 mai 1953, un Comité de Comptabilité et de Statistique fut formé. Les personnes suivantes en sont membres: Eugène Bourassa, Régina, Saskatchewan; Harry E. Dale, Nanaimo, Colombie Britannique; Walter W. B. Dick, Moncton, Nouveau-Brunswick; Robert G. Goodman, Winnipeg, Manitoba; Paul-Emile Olivier, Montréal, Québec; S. Vic Pryce, Calgary, Alberta; Paul Shannon, Montréal, Québec; Max B. Wallace, Toronto, Ontario; Murray Ross, assistant-directeur de l'Association des Hôpitaux du Canada agit en qualité de secrétaire.

De plus, le département dans chaque province de qui relève les hôpitaux, ainsi que le département fédéral approprié, furent invités à désigner un représentant sur le Comité.

Après que le comité fut organisé, il ne fut pas possible de tenir plus qu'une assemblée. Le comité s'est réuni à Toronto les 4-5-6 avril de cette année et tous les membres étaient présents.

De plus, les représentants gouvernementaux suivants assistèrent à l'assemblée: Bernard R. Blishen du Bureau Fédéral de la Statistique; Robert M. Clements pour la Saskatchewan; Bert H. Foster pour l'Alberta; Herbert Hart pour la Nouvelle-Ecosse; Just Letellier pour le Québec; Docteur E. R. Rafuse pour le Manitoba; et C. J. Telfer pour l'Ontario.

Etaient également présents les observateurs suivants: Professeur J. D. Campbell de l'Université de l'Alberta, Edmonton; R. W. Erdmann du Ministère Provincial de la Santé, Toronto; Ocean G. Smith de l'Association des Hôpitaux de l'Ontario, Toronto; Alfred T. Story d'Owen Sound; Eric Willcocks, Toronto.

Etaient également présents MM. Murray Ross et Donald MacIntyre, assistants directeurs de l'Association des Hôpitaux du Canada.

Cette réunion fut consacrée à étudier d'une façon détaillée *Le Manuel de Comptabilité des Hôpitaux du Canada.* Les membres présents sont d'avis que le Manuel de Comptabilité est employé extensivement et que les hôpitaux de toutes catégories s'en servent comme guide.

Il fut convenu qu'il n'y avait pas présentement de raison justifiant des changements majeurs dans les principes exposés dans le manuel ou dans sa présentation vu que c'est seulement au cours de la présente année que la dernière des provinces continentales à adopter le texte comme base du système de comptabilité recommandé pour les hôpitaux dans cette province.

Plusieurs de ceux qui étaient présents furent d'accord qu'une plus grande importance devrait être accordée à la départementalisation des comptes de l'hôpital. Il fut aussi proposé que des exemples de rapports financiers adaptés à des fins de publication soient inclus dans une revision

(Suite à la page 116)

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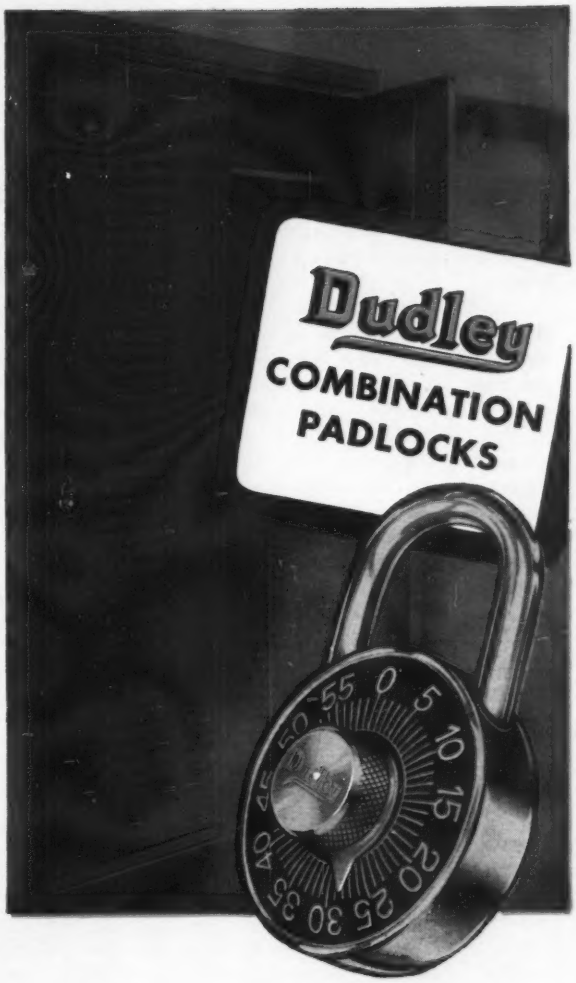

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Dietary Facilities

(concluded from page 54)

lar to home service, have proved satisfactory to the nursing department and patients' comments have been favourable. Breakfast is served from 8 a.m. to 9 a.m.; lunch from 12 noon to 1 p.m.; dinner from 5 p.m. to 6 p.m. The more substantial dinner in the evening prevents numerous complaints about inadequate suppers and evening hunger.

Trays are assembled in each ward kitchen. The cold foods, such as desserts, milk and butter, are placed on the trays by dietary aides. Each tray is carefully checked for completeness by the staff dietitian or student nurse assigned to the department. They are then wheeled to the wards where hot food is served at the patient's door from the electrically heated wagons.

Trays are delivered to the patient's bedside by dietary aides. These girls are also responsible for iced water in bedside thermoses and any nourishments for those on therapeutic diets. An intercommunication system between the ward kitchen and the dietitians' office on the sixth floor keeps the main kitchen in contact with ward kitchen requirements.

Dietary Manual and Therapeutic Diets

A diet manual has been prepared for use on all the wards. Although it is longer than is desirable, periodic revision is part of the plan and less popular diets will be changed or eliminated.

The standard hospital diets are known as clear fluid, full fluid, advanced full fluid, soft, light, and full. The "advanced full fluid" diet is a progression from the full fluid to the light or full diet, and contains the addition of easily digested solid foods such as fowl, fish, white bread, and potatoes. The soft diet is for patients who are unable to chew. Pork, ham, gravy, highly seasoned foods, and strongly flavoured vegetables are omitted on the light diet.

"Salt free" or "salt poor" diets are not used. Restricted sodium diets are ordered according to a specific number of grams of sodium. Traditionally used pureed foods which are seldom eaten by the patients have been replaced by the natural forms of foods which are low in residue.

Gastric diets are divided into four groups, Gastric Nos. 1, 2, 3 and 4. This represents a gradual progression from hourly milk and cream feedings on a Gastric No. 1 to a diet containing tender meat and vegetables on Gastric No. 4. An innovation has been made in serving the therapeutic diet trays at the same time as the regular trays and from the same food wagons.

Cafeteria

The cafeteria has a double serving line which accommodates all hospital staff and visitors to patients. All staff taking their meals in the hospital are required to eat in the cafeteria or in the main floor snack bar. If staff members wish to bring their own lunches they are not allowed to eat in offices, lounges, or areas other than the cafeteria.

A selection of two main dishes is offered at each meal. For example, these may be either a choice of a salad plate or a hot luncheon dish, or two hot luncheon dishes. In addition to this a sandwich is always available, as well as a choice of two desserts.

All food is sold "a la carte" and everyone pays on a cash basis. Bag lunches may be supplemented with soup, dessert, or beverage. Interns pay but are given a stipend which takes this into consideration. Student nurses are allowed a choice of food; their meals are recorded and charged to the nursing education department. This has proved most satisfactory from a dietary point of view and we find the psychological effect is good and staff are much happier making their own selections.

All professional and non-professional staff eat in this one dining area. There is no segregation according to rank. Each person selects his own tray and food at the cafeteria line and carries it to the dining area. Following the meal, he carries his own tray and dishes to a moving belt which delivers them to the dish-washing room.

A snack bar located on the main floor is operated for the convenience of hospital visitors.

Teaching Responsibilities

In addition to providing food service to patients and staff, the dietary department assumes due responsibility for the teaching function which is a major interest in a university hospital.

Student nurses spend a four-week period in diet therapy. The first three weeks are in their junior year, the last week is in their senior year. A minimum amount of time is spent in preparation and delivery of nourishments to the patients and in the preparation of special desserts for therapeutic diets.

Emphasis is placed, in the students' training, on opportunities for learning the relation of good nutrition to health and disease. This is done through practice in checking and writing standard and therapeutic diets, under the supervision of a dietitian. Patients, particularly those on therapeutic diets, are visited and their diets are discussed. They also observe the dietitians instructing patients, to be discharged, on therapeutic diets. Diet case histories are studied and written during the three-week period. A large project consists of compiling a scrapbook. Some of the work included in this are samples of all the standard and therapeutic diets marked by the student herself, family meals for a week, school lunch planning, calculation of dietary work sheets, and summary of important facts in their assigned readings.

The fourth week of diet therapy, in the senior year, assists the student in obtaining an over-all picture of menu planning, work sheets, et cetera. The assignments are carefully checked and returned to the student for reference and future use.

Future plans of the dietary department in this teaching hospital are to provide an approved course for dietetic interns.

Immunization Information

A supplement to the booklet *Immunization Information for International Travel* has just been released by the Public Health Service of the Department of Health, Education, and Welfare, Washington, D.C. It carries changes made in immunization requirements from June 1954 to June 1955. Persons having a 1954 edition of the booklet may obtain copies of the supplement, free of charge, from the U.S. Public Health Service, Division of Foreign Quarantine, Washington 25, D.C.

The booklet, including the new supplement, may be purchased for 20¢ from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. A 25 per cent discount is allowed on orders of 100 copies or more delivered to the same address.

◀ Provincial Notes ▶

British Columbia

CAMPBELL RIVER. A double-corridor plan for the new Campbell River and District General Hospital has been approved by the provincial government and will be one of the first of its kind in British Columbia. Drawings for the 62-bed institution have been done by architects Underwood, McKinley & Cameron of Vancouver. The approximate cost of the new hospital will be one million dollars.

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INVERMERE. Plans for a new 23-bed hospital for the Windermere district have been given government authorization. The architect, Paul Smith of Trail, has been commissioned to proceed with working drawings and specifications.

* * * *

PRINCE GEORGE. Two cheques totalling $1,067.80 were presented to the Prince George and District Hospital by the Prince George Kinsmen Club, to cover the cost of a new obstetric table and a new post-anesthesia stretcher. The hospital is now making plans for a new building which will cost over $2,000,000.

* * * *

PRINCE RUPERT. Construction of the new x-ray and laboratory department in the Prince Rupert General Hospital was expected to be completed this month. The cost of the new department, which is located on the main floor of the hospital, in a section formerly used for storage space, is about $18,000. New x-ray equipment valued at $20,000 will be installed.

* * * *

SIDNEY. The 68-bed Rest Haven Hospital and Sanitarium has almost completed its $45,000 improvement program. An automatic sprinkler system for fire protection has been installed, the laundry building has been renovated, and new equipment has been added to the kitchen. The funds for the program were provided by the Seventh-Day Adventist church.

* * * *

VICTORIA. The new $130,000 Wayside House, a Christian Science nursing home, is now under construction. It will replace the old Wayside House which was founded in 1931 and licensed in 1942 as a private hospital. The project is being financed by donations from across Canada and the United States. The architects are Wade, Stockdill and Armour of Victoria.

* * * *

WILLIAMS LAKE. Work on the new addition to War Memorial Hospital got under way late in June. The lowest tender submitted for construction of the project amounted to $29,123.40. War Memorial Hospital showed an operating surplus of $3,859 for the first six months of this year.

Alberta

BANFF. An exerciser for polio patients was recently given to the physical therapy department of the Mineral Springs Hospital by the Canadian Legion Foundation for Poliomyelitis in Calgary. The piece of equipment, valued at $15,000, makes possible 100 different arrangements for remedial exercises.

* * * *

BEAVERLODGE. Work began recently on the new 20-bed Beaverlodge Municipal Hospital. Contracts awarded for the construction of the building totalled $150,110. The old nine-bed hospital will be remodelled as a nurses' residence when the new one is completed.

* * * *

CALGARY. A 41-bed chronic disease nursing unit is now being constructed by the Lutheran Welfare Society in Alberta, and will cost around $170,000. The architect is John A. Cawston, Calgary.

* * * *

LAC-LA-BICHE. The new 48-bed wing to St. Catherine's Hospital is now nearing completion at a cost of about $450,000. The official opening of the addition is expected soon.

* * * *

SPIRIT RIVER. The ground was broken in July for a $330,000 addition to the Holy Cross Hospital operated by the Grey Nuns order. The 39-bed addition is part of a $242,000 building and renovation program. Completion of the first floor is expected by Christmas, when it will be opened for immediate use. The remainder of the building is scheduled for early next spring.

Saskatchewan

MOOSE JAW. A fire in the clinical laboratory of the Moose Jaw Union Hospital caused more than $100 damage last July. The fire occurred when phenol crystals, which are inflammable, were being melted down over a Bunsen burner.

* * * *

REDVERS. A $110,000 enlargement and renovation program has been completed at the Redvers Union Hospital. The 24-bed hospital was built in 1946.

* * * *

WAKAW. Work began in June on the new Wakaw Union Hospital which is to replace the old 16-bed institution. The cost of the hospital is estimated at about $100,000.

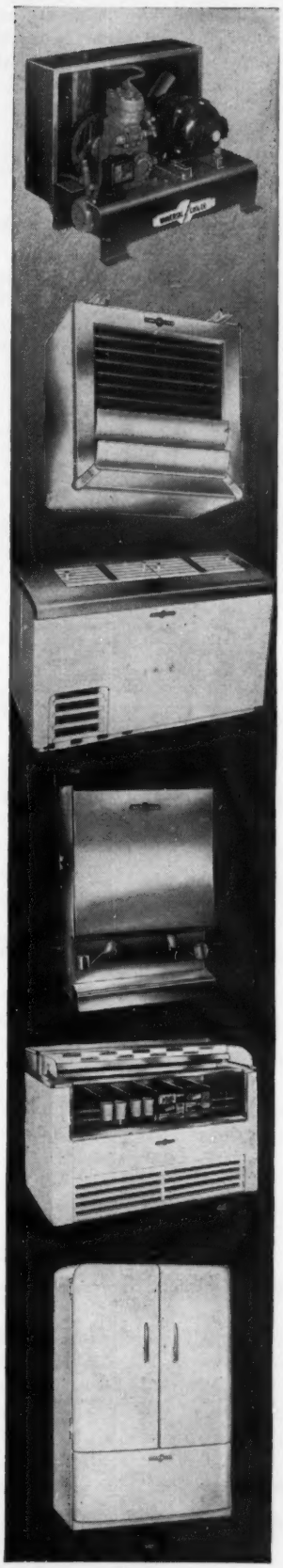
* * * *

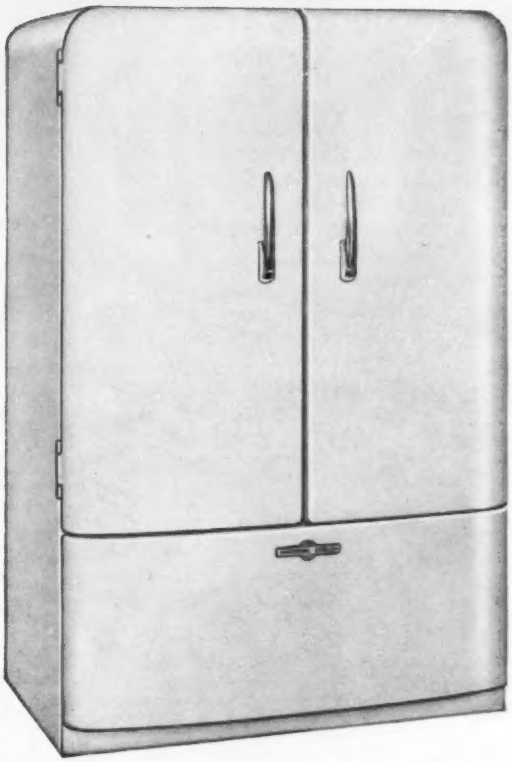
WEYBURN. The new nurses' residence at the Saskatchewan Hospital was completed and opened in June at a cost of approximately $750,000. One of the features of the residence is a large solarium on the roof.

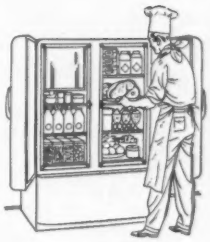
Manitoba

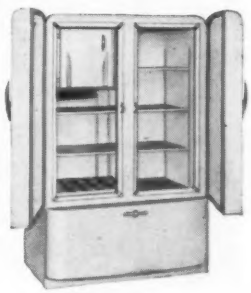
EMERSON. The new 10-bed Emerson Nursing Unit was opened recently. On the opening day the unit was pre-

(Continued on page 72)









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(Continued from page 70)

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* * * *

MINNEDOSA. The purchase of the W. E. Clark home by the Minnedosa District Hospital will relieve the hospital's need of additional lodging facilities. The home will be converted into a 14-bed nurses' residence. Purchase price of the structure is $15,000. The 26-bed hospital was paying an additional $700 annually for outside accommodation for nurses.

* * * *

WINKLER. The Bethel Hospital has decided to continue operating on a charitable basis, although a deficit of $5,883.46 was reported for 1954. The 36-bed Mennonite institution was founded in 1936 under a self-help hospital system. Members of the community are being requested to make donations.

* * * *

WINNIPEG. A hydrotherapy rehabilitation centre is to be constructed, in four separate stages, at the Princess Elizabeth Hospital. The new centre will be used for hydrotherapy for poliomyelitis patients, victims of rheumatism and arthritis, nervous disorders, strokes, cerebral palsy, and victims of industrial accidents. The cost of the first stage is estimated at about $100,000.

Ontario

HUNTSVILLE. The new wing of Huntsville District Memorial Hospital was opened recently. It adds 20 beds to the hospital's former capacity and will be used primarily for chronic cases and older people requiring special nursing care. Renovations have also been made in the earlier building which will provide several new facilities. The total cost of the wing and alteration program was about $106,000. The architect was W. B. Hackett, Toronto.

* * * *

KINCARDINE. Work began in July on the $250,000 extension to Kincardine General Hospital. The 18-bed addition is designed to be the nucleus of an entirely new hospital as the need arises. A tentative date for completion of the building has been set for May, 1956. The architect is Douglas E. Kertland, Toronto.

* * * *

LONDON. The Salvation Army's Bethesda Hospital was closed in August and is now being reorganized as a Home and Hospital for Unmarried Mothers. Provision is being made for sleeping quarters, sitting rooms, recreational rooms, chapel and educational facilities. When reorganization is completed the hospital will have a 47-bed capacity. Bethesda is classed as a private hospital.

* * * *

MINDEN. The new Red Cross Outpost Hospital was officially opened in June by the Hon. Leslie Frost, premier of Ontario. The eight-bed, $69,000 hospital is the first to be opened in Minden and is one of 23 Red Cross outpost hospitals in the province. It will give emergency and obstetrical service but will not provide major surgery.

* * * *

NORTH BAY. Work began recently on nine buildings which constitute the first phase of construction of the new Ontario Hospital at Cooks Mills, north of here. A five-storey nurses' residence, an administration building, and five pavilions accommodating 180 patients each are among the buildings now under construction. These first structures will cost more than $5,000,000, exclusive of equipment. When completed the hospital will have a 1,200-patient capacity and will be as self-contained as an average small town, with its own water and sewage-disposal systems.

* * * *

NORTH BAY. A sod-turning ceremony in July initiated construction on a $1,000,000 addition to St. Joseph's General Hospital. Although bed space in the existing 124-bed hospital will be increased by only 40 beds, the seven-storey addition will supply space for other needed services. Completion of the structure is scheduled for the fall of next year.

* * * *

OAKVILLE. Construction has begun on a 125-bed addition to the Oakville-Trafalgar Memorial Hospital. The $1,767,000 extension is to be completed by next spring and will provide facilities which have been needed for some time. Hospital officials have reported that the present building is never below 90 per cent occupancy.

* * * *

PALMERSTON. The new addition to the Palmerston General Hospital was formally opened last June. The approximate cost of the 20-bed institution was $179,000. The Hon. Mackinnon Phillips, M.D., provincial minister of health, officiated at the opening ceremonies.

* * * *

SHELBURNE. The Shelburne District Co-operative Nursing Centre, opened as a private hospital in 1951, has recently become, by provincial edict, a public institution. Now as the Shelburne District Hospital it is entitled to government grants.

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TORONTO. The Toronto East General and Orthopaedic Hospital opened its new x-ray building recently. The $106,000 building contains $56,000 worth of specialized equipment and allows for further expansion of the hospital. Construction began in November, 1954.

* * * *

WINGHAM. Now under construction is a new chronic patients' wing to Wingham General Hospital. It will provide 48 more beds for the chronically ill and two additional active treatment beds. The wing will cost about $290,000. A 35-bed nurses' residence is also being built at this time.

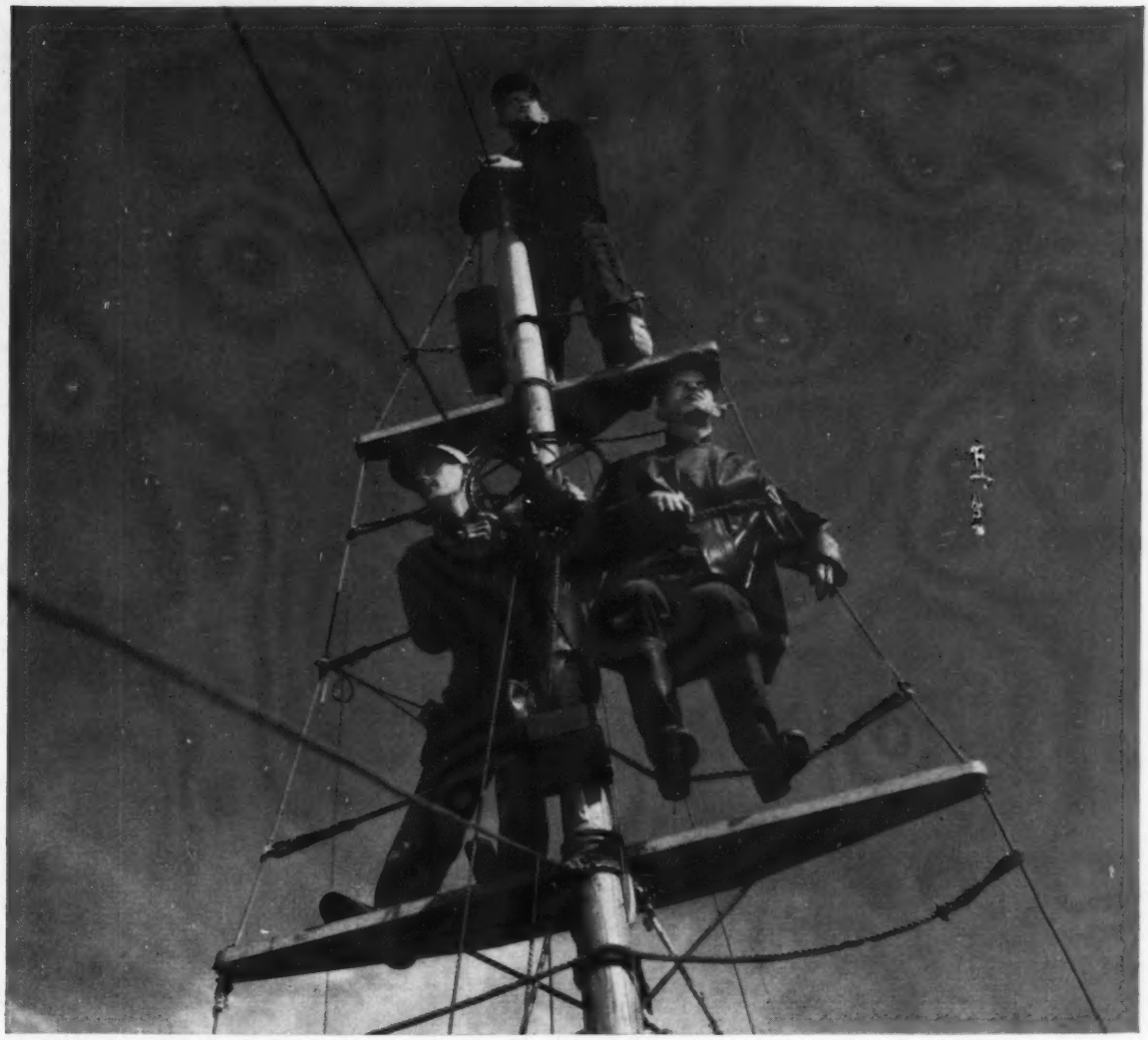
* * * *

WOODSTOCK. The 560-bed building for tubercular patients at the Ontario Hospital is now under construction. The building will cost over $2,000,000.

Quebec

MONTREAL. The provincial government has decided to convert the old Hôpital Ste. Justine into a hospital for cancer patients and invalids. The building was purchased by the government for $3,000,000 and conversion will take place when the new Hôpital Ste. Justine is opened.

(Concluded on page 98)



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With the Auxiliaries

Garden Tour Aids Oakville Hospital

A three-day garden tour, sponsored by the women's auxiliary to the Oakville-Trafalgar Memorial Hospital, Oakville, Ont., brought about $5,000 in cash return and over 2,500 visitors to the five lakeshore estates included in the tour. People making the tour came from many parts of the United States and Canada. Since the tours were started five years ago, proceeds have been used to provide equipment for the hospital, including linens, surgical instruments, insulated food carts, awnings, furnishings for a nursery in the new obstetrical wing, and three apartments for the nursing staff. The funds raised this year will go to the auxiliary's pledge of $20,000 toward the new addition that is now being built to the hospital.

* * * *

Art Exhibit Provides New Equipment

The auxiliary to the Armstrong and Spallumcheen General Hospital, Armstrong, B.C,. recently sponsored an art exhibit, with the proceeds going towards the purchase of a new x-ray machine for the hospital. The exhibit featured work of art groups in Kamloops, Revelstoke, Armstrong, Prince George, Golden, and Cranbrook, and included paintings in both water colours and oils.

* * * *

Ottawa Auxiliary to Spend Up to $12,000 This Year

The women's auxiliary to the Ottawa Civic Hospital has voted to spend up to $12,000 on hospital projects for the coming year. Last year $9,500 was spent by the group. Among the projects scheduled for 1955-56 are renovation of at least two public wards, a program of play therapy for the children's ward, and provision of furnishings and additions for the Nursing Education Building. A special project is that of making the out-patient department more comfortable. As in preceding years, $1,000 will be used to support post-graduate work for staff nurses, and another $1,000 will be available as an emergency fund for student nurses.

Auxiliary Donation Provides New X-Ray

A cheque for $1,700, presented to St. Mary's Hospital, London, Ont., by the women's auxiliary, will go toward purchase of a new x-ray unit for the hospital. Previously patients at St. Mary's had to be taken to another hospital for x-ray treatment. The auxiliary has raised $1,753.77 during the past year through such projects as the May Festival, a fashion show, and an anniversary tea.

* * * *

N.B. Auxiliary Holds Annual Meeting

The annual meeting of the Ladies' Aid to the Tobique Valley Hospital, Plaster Rock, N.B., was held recently and a bank balance of $1,073 was reported to the group. Food sales, card parties, and a rummage sale helped to raise the money, most of which will go toward the purchase of a new anaesthetic machine for the hospital.

* * * *

Aberdeen Hospital Auxiliary Donates $500

The Ladies Auxiliary to the Aberdeen Hospital, New Glasgow, N.S., has donated $500 towards the purchase of such items as toasters for the kitchen and silver pitchers for patients' trays. Recent fund-raising projects sponsored by the group include a rummage sale and tag days held in New Glasgow and several near-by communities. A cheque for a dishwasher for the new hospital has also been sent by the auxiliary.

* * * *

Sick Children's Auxiliary Raises $12,596

Of the $12,596 raised by the 5-Fifty-5 Shop of the Women's Auxiliary to The Hospital for Sick Children, Toronto, Ont., $4,000 will go for a half-time social worker and secretarial aide for adolescent diabetics, epileptics, patients with chronic nephritis, and allergy cases; $2,000 to the research department; $4,000 for special nursing on the wards; and $850 for roof playground equipment.

Activities of the auxiliary during the past year included assisting in the occupational therapy room, working in the records office, keeping the waiting rooms supplied with magazines, and running the 5-Fifty-5 Shop, which sells handicrafts and other gifts made by members. Four thousand hours of work were spent in staffing the shop.

New services include assistance in the admitting department, reading to children in the eye wards, and clerical assistance in the medical library.

* * * *

North Harwich Society Furnishes Room

A cheque for $1,000 was presented to the Public General Hospital, Chatham, Ont., by the North Harwich Assisting Society recently. The donation, first instalment of a $1,500 gift, will be used to furnish a two-bed room in the new wing of the hospital. The society, which currently has 40 members, evolved from an organization founded during World War I to do Red Cross work.

* * * *

Sun Deck For Crippled Children

The Children's Hospital Aid Society has donated $20,000 to the Alberta Red Cross Crippled Children's Hospital, Calgary, Alta., to be used for the building of a glassed-in sun deck for patients. During 1954 the aid raised $28,036 through such projects as the sale of Easter seals and football programs, and the annual Easter Tea. The next project on the list is the furnishing of the sun deck.

* * * *

Auxiliary Cheque To Furnish Hospital Rooms

A cheque for $1,400 was presented to Sister M. Veronica, administrator of St. Joseph's Hospital, Saint John, N.B., at the June meeting of the hospital auxiliary. The Sisters of Charity will use the money to furnish rooms in the new 200-bed addition to the hospital. The sum was raised by the auxiliary at their annual Maytime Tea.

* * * *

Violet Day Successful

At the May meeting of the Ladies' Auxiliary to St. Joseph's Hospital, Peterborough, Ont., a very successful Violet Day, in which the receipts totalled $1,345, was reported. The membership campaign, then at the half-way stage, revealed 1,289 members for the city.

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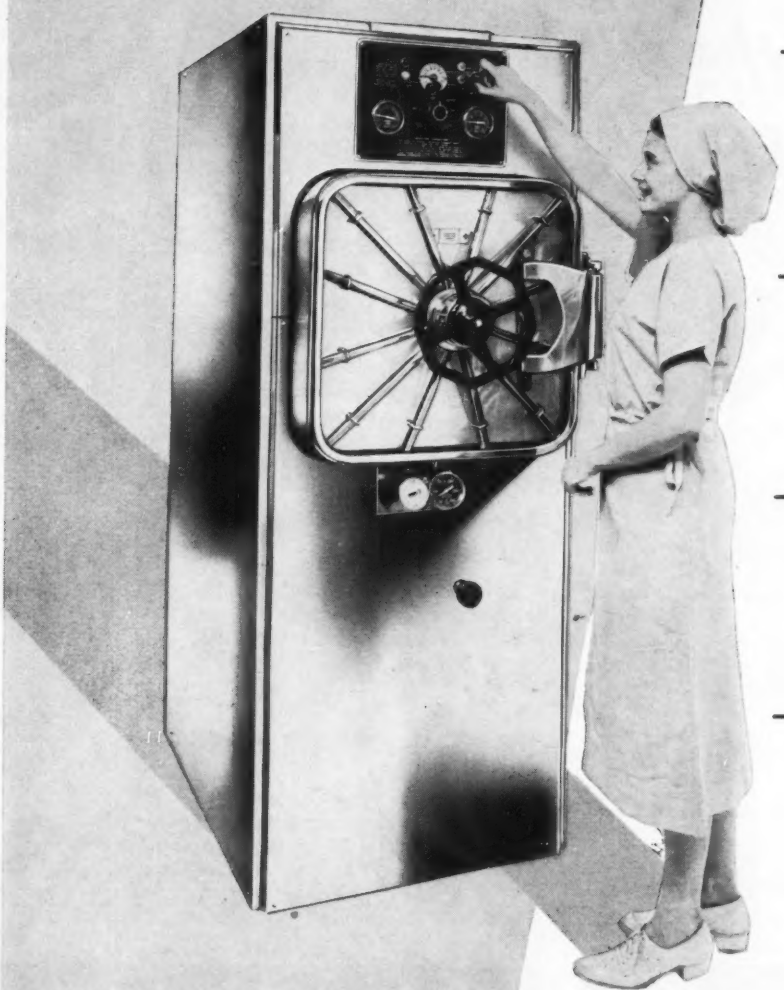

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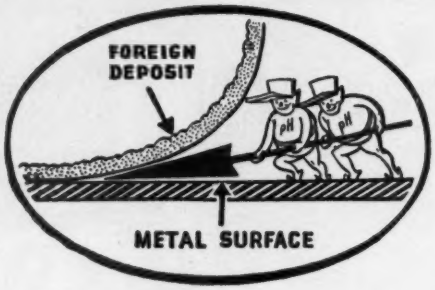

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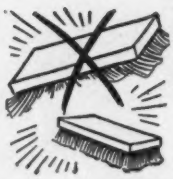

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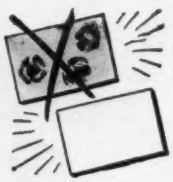

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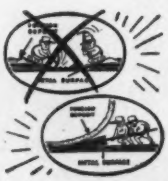

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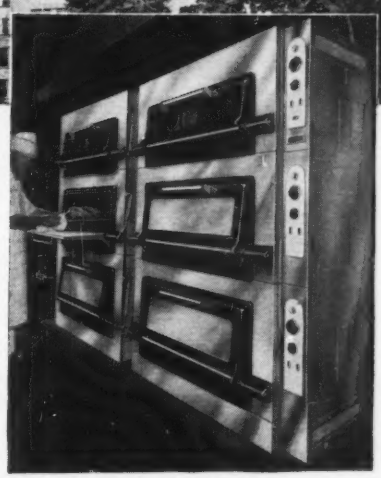

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Book Reviews

THE RURAL HOSPITAL: ITS STRUCTURE AND ORGANIZATION. By Dr. R. F. Bridgman, Deputy Director of Health of the Department of the Seine, France. World Health Organization: Monograph Series, No. 21. Geneva, 1955. Pp. 162. Price, $4.00. Illustrated. United Nations Division, Ryerson Press, Toronto 2B.

Dr. Bridgman speaks of the rural hospital from the socio-biological stand-point as the smallest curative unit serving a rural community, its structure varying with the basic features of country life. There is now a strong tendency to expand the scope of the hospital to cover the whole community, through out-patient care and preventive measures, and it may also cover the community's health education and serve as a demonstration centre for general hygiene work. Countries not possessing a system of rural hospitals can introduce this concept of combined health activities by creating hospital health-centres, taking care that this system does not develop into a twofold health system accentuating the distinction between town and country.

The monograph endeavours to justify the statement that the hospital/health-centre in its most comprehensive form should provide the surrounding district with preventive and curative services and, at the same time, should serve as an outpost for the hospitalization of confirmed cases of disease. It is stated, however, that the problem is not as simple as this statement would make it seem. Many questions arise such as provisions for maternity cases, facilities for infectious patients, care of social cases and convalescents. In-patient care in the rural hospital meets with obstacles, such as disproportionate operating costs due to the small number of beds occupied and problems of staffing and of technical equipment. A hospital with from 25 to 30 beds can never provide composite diagnostic or therapeutic services, owing to its very limited facilities.

Dr. Bridgman first places the rural hospital within the framework of a general hospital organization. Using many illustrations and floor plans throughout, he deals with the practical aspects of his subject—the structure of the hospital (including the necessity for flexibility of functions), the various services which it might comprise, and its equipment. He points up the need for hospitals to be so designed as to permit adaptation to developments in the health situation, with buildings as simple and as little mechanized as possible, since qualified personnel for on-the spot repairs may not be available. A chapter is devoted to the staff, as the quality of treatment will depend more on personnel than on the premises.

The author also discusses the manner in which rural hospitals can be integrated into the general hospital system of a country or a region and the means of financing hospitals. He considers types of organization suitable for various regions—tropical zones, those which are under-developed, those in the course of economic development, and those which might be termed "advanced".

Dr. Bridgman has an extensive knowledge of hospital organization in widely differing regions of the world and has made a thorough study of the rural hospital. He has avoided giving proposals for cut-and-dried formulae or rigid recommendations; rather, the monograph is meant to serve as a practical guide to those responsible for providing the best possible medical care in rural areas with the object of improving health and living standards. —*W. D. P.*

* * * *

CUMULATIVE INDEX OF HOSPITAL LITERATURE, 1950-1954. Pp. 513. Price, $6.00. Published by the American Hospital Association, Chicago, Ill., 1955.

The Index lists articles in more than 300 journals in the hospital and related fields published during the past five years. It includes references to hospital literature in medical, nursing, public health, business, architectural, and other periodicals.

This cumulation was prepared for three specific purposes: (1) to enable a reader to locate a particular article which he had read earlier or to which specific reference had been made; (2) to prepare complete or selective bibliographies on a given topic as a basis for study of that subject; (3) to make possible an acquaintance with what is being written in the field and to stimulate further reading.

Also available is the 1945-1949 *Cumulative Index of Hospital Literature* at a cost of $5.00. The AHA Library supplements the five-year indexes with the *Index to Current Hospital Literature*, which is published every six months. All articles pertaining to hospitals or hospital departments that have appeared in the past six months are indexed. Subscriptions are $3.00 per year.

* * * *

MANUAL FOR HOSPITAL PURCHASING AND INVENTORY CONTROL. By E. C. Wolf, Minneapolis. Pp. 143. Price, $4.00. Burgess Publishing Co., Minneapolis 15. 1955.

The author, who is director of purchases at St. Mary's Hospital, Rochester, Minn., points out in his preface that it is probably impossible to set up a rigid procedure that can be followed entirely in every hospital in the country. He hopes, however, to offer a guide which can be followed in whole or in part in any institution, large or small. The manual attempts to treat the subject not just from the angle of the purchasing agent but from the broad view of a department of procurement, assignment, and uses. In addition to 23 chapters the book contains two appendices, one Fessenden's "Guide to hospital purchasing", and the other a bibliography on accounting procedures.

Chapter headings include group purchasing; principles and ethics; public relations; central stores department; trade names and brands; centralized purchasing; specifications; use and value of inventory control; mechanics of centralized purchasing, receiving, storing, issuing and manual method of inventory control; inventory control and departmental cost acquisition by machine methods; standardization and simplification; conservation of materials and supplies; importance of testing and research; and the importance of a hospital formulary.

The manual is actually a compendium of articles dealing with many phases of the purchasing function in hospitals. In addition to the writings which the author has selected, he has

(Concluded on page 102)

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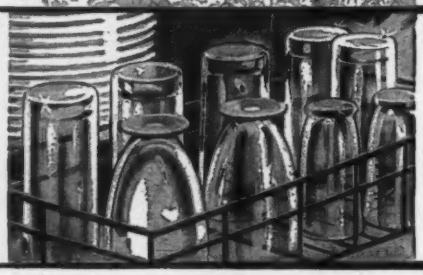

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Develop Departments—not Compartments

T. E. Kirk, M.D.,
Medical Superintendent,
Camp Hill Hospital,
Halifax, N.S.

WE ARE all familiar with the esponsibilities of the board of trustees, the medical board, and the administrator, who is the vital link between these two. We are also familiar with the organization of the boards mentioned, including the various committees which are normally established within each one, to deal with the different aspects of hospital policy and operation. With the advent of new techniques, special types of scientific equipment, and highly trained professional and technical personnel, the activity of the hospital becomes increasingly complex. In support of the professional clinical staff, hospitals have a large number of ancillary services, all of which play an important part in the restoration of the patient to good health and return to his place in society.

We have observed that such ancillary services are not always adequately organized from an administrative point of view. There is a definite trend for each one to become compartmentalized. Under such circumstances, there is a certain tendency on their part to lose sight of the basic reason for the existence of a hospital, *i.e.*, the best care of the patient. All personnel employed in our institutions must direct every possible resource towards this goal.

It is essential that all departments have a general knowledge of the activities, problems, and procedures of other ancillary sections. The functions of these sections constantly overlap and, where such overlapping occurs, there must be full agreement and understanding in respect to responsibility and methods.

Purpose of Conferences

The establishment of regular administrative conferences for the heads of ancillary sections is of great value in educating such groups with respect to general organization and administration, as well as to the special activities of each section. Such a conference should serve two main purposes:

1. The dissemination of policies as determined by the board of trustees and the medical board;

2. An opportunity to discuss problems arising in individual areas and their relationship to other areas.

Through joint discussion, many apparent problems can be resolved quite readily. Such discussion will assist in crystallizing sectional programs and thus should result in more efficient service throughout the hospital. In a word, it should produce the coordination which is essential for the best functioning.

With the active operation of such a conference, it is possible for the heads of ancillary services to hold meetings with their staff and transmit to them information regarding their own specific responsibilities and their place in the over-all organization. They have the opportunity to emphasize to all members of their staff the fact that every employee, irrespective of his job, has a definite share in the ultimate result with respect to the care of the patient. This type of education is invaluable in the maintenance of morale and the best possible personnel relationships throughout the hospital staff.

As the need became obvious, it was decided in our institution, to establish such a conference some years ago. The following accessory services are represented on the basic committee: medical administration; general administration; nursing service; dietary service; and admission services.

These represent the larger groups of employees. However, when special problems present themselves in certain sub-sections, such as maintenance, equipment, et cetera, the heads of such are invited to attend. Originally, it was planned to hold monthly meetings. However, within a short time this type of conference became so popular that it was necessary to hold such meetings at more frequent intervals, even weekly during some periods.

At the time this committee was organized, some heads of ancillary services entertained doubts as to its potential value. However, very shortly all members became enthusiastic in respect to its importance and felt that it should become a permanent committee with the institutions. ●

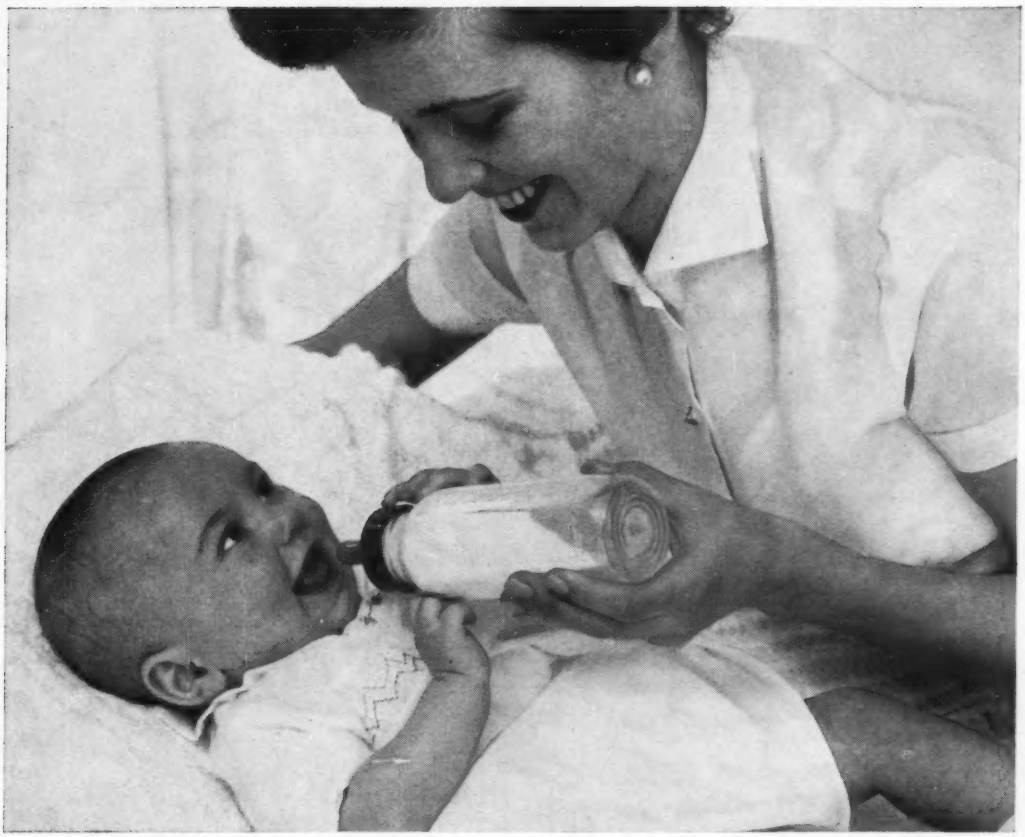
One Doctor for every 948 Canadians

There is one doctor for every 948 Canadians, according to a report released recently by the Department of National Health and Welfare. Canada had an all-time high of 16,031 active doctors as of June, 1954. Quebec, Ontario, and British Columbia have been better supplied with doctors than the rest of the provinces for many years. British Columbia now has the lowest provincial ratio recorded, with one doctor for every 777 persons.

Especially notable has been the increase in the number of women doctors in the past 30 years. Last year, Canada had 638 female physicians—about four per cent of the total active civilian supply. In 1921, women doctors formed only 1.7 per cent of Canada's doctors.

Concentration of doctors in urban centres has continued in the post-war years, the 1954 survey indicated. In 1947, 70.8 per cent of Canada's physicians were located in centres of 10,000 or more. By 1951, the proportion had risen to 73.2 per cent and in 1954 it stood at 78.7. Provincial variation in 1954 was between 44.1 per cent for Newfoundland and 78.7 per cent for Ontario. The survey also pointed out that the trend towards specialization has continued.

Since June 1951, 708 doctors have immigrated to Canada. One-third of these physicians are in private practice and most of the remainder are employed by hospitals as staff or senior interns. Graduates of Canadian medical schools have also added considerably to the total. Nearly 900 students graduated in 1954, 54 of them from the new medical school at the University of British Columbia.



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Here and There

The Story of Val-de-Grace

When the Croix de Guerre for overseas service was presented recently to the two training schools of France's Army Health Service, the honour included as well the old training school of the Val-de-Grace, the parent establishment of the Army Medical Corps.

"Val-de-Grace" is the name of a former convent of Benedictine nuns, built in the 16th century just outside Paris, in the Bievrès valley. As the young Queen Anne of Austria, wife of Louis XIII, was a great friend of the Abbess of the Val, the Benedictines received permission to settle down at the gates of the capital, in the suburb of St. Jacques. They took over the buildings of a former country residence which had belonged to the Valois family and then to the Bourbons.

After the death of the King, Anne of Austria, who was then Regent of the Kingdom, gave a further mark of favour to her Benedictines by having built, on the same site, a new monastery, the plans for which were designed by the famous architect Mansard. It was the young King, Louis XIV, then seven years of age, who in April 1645 placed the foundation stone of the new church. Until her death in 1666, the Queen remained not only the benefactress, but also the great friend of the Val-de-Grace. She had her own apartments there, and even today, the room she occupied on the first floor of the Anne of Austria wing is still shown to visitors.

The French Revolution transformed the convent into a general military hospital, then into a training hospital whose professors were famous military doctors and surgeons of the time, such as Desgenettes, Larrey and Percy whose names, alongside those of the generals of the Emperor Napoleon, are inscribed on the Arc de Triomphe of the Etoile.

Half a century later, the Val-de-Grace became a postgraduate training school to which young military doctors, surgeons and pharmacists, after completing their normal course of study at the Faculty of Medicine, came for a course of post-graduate training. Since that time, the "Val" has continued, as expressed in the mention it deservedly won after the First World War, "to inspire in the officers of the Health Corps the pursuit of knowledge and the spirit of sacrifice."

Many chairs were founded at the Val-de-Grace at a time when none yet existed in the universities: collective medicine, epidemiology, social hygiene, war surgery, special surgery, and bacteriology, for example. Many discoveries are due to former students and masters of the "Val", as for instance the anti-typhoid vaccine of Vincent which, at the beginning of World War I, saved the French armies and the Allies from a real epidemic disaster—*From an article by Georges Marey.*

Scotland Experiments

The Report of the Department of Health for Scotland for 1954, in an interesting section on treatment of the mentally ill, refers to the open-door system operated at several Scottish mental hospitals. At Dingleton Mental Hospital at Melrose, patients have been given complete freedom from locked doors. As a result they are now much more friendly and easily managed. Psychiatrists from many countries have paid visits, and other hospitals, including some English ones, have arranged to second staff to Dingleton to study these methods.

Another experiment, at Craig Dunain Hospital, is the appointment of a vocational adviser. In the past, discharged patients have often had relapses, sometimes because of difficulties arising from their employment. Now this vocational adviser and the medical superintendent have made an assessment of the patients and found out that many if taught suitable skills, might be gainfully employed by the hospital or be able to hold down jobs in the outside world. The training is expected to be of high therapeutic as well as of practical value, and a scheme is at present being considered for providing workshops within the hospital in which selected patients might be trained and also gainfully employed in the production of saleable goods—*The Hospital, May,* 1955.

New Unit Opened in Hampstead

A most important unit was opened recently at New End Hospital, Hampstead, England by H. R. H. the Duke of Edinburgh. It is a new endocrine unit, largely made possible through the generosity of the King Edward's Hospital Fund for London.

New End Hospital already possessed possibly the largest thyroid unit in the country, and the new building has provided an extension, enabling the unit to be augmented by 30 beds. There was already also a radioactive iodine centre, recently formed at the hospital and mainly used in connection with thryoid cases. The various activities of the enlarged unit will include research investigation and treatment of thyrotoxicosis to be undertaken for the Royal Cancer and Brompton Hospitals; in addition, the neuro-surgeon at Whittington Hospital, Highgate, is arranging for investigation and treatment of brain cancer by radio-active phosphorus through the agency of the radioactive unit at New End Hospital.

The thyroid unit was initiated in 1932 by Sir Thomas Dunhill, and from small beginnings it has grown during the years in size, activity and reputation. The clinic has attracted physicians and surgeons from many parts of the world, including many internationally famous names connected with the study of the thyroid — *Hospital and Health Management, July,* 1955.

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17 Million Children and Mothers Receive UNICEF Benefits

Some 16.9 million children and pregnant or nursing mothers received direct aid during the first six months of 1955 from the principal health and nutrition programs of the U.N. assisted by the United Nations Children's Fund (UNICEF), the agency has announced.

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"A Million and One Nights of the Bath"

(The following are further excerpts from an article entitled "A Million and One Nights of the Bath", prepared by the Crane Co. of Chicago, Ill., to celebrate the company's 100th anniversary. See "The Canadian Hospital", August, page 72—Edit.)

The 13th century saw the first timid introduction of public vapour baths in European cities. They were called "hothouses" in England. Even these had a sinister connotation—there were separate rooms for the multitude of lepers. But the city of Bologna, Italy, made a forward move and appointed a city physician. And in the latter half of the 13th century, a health officer was elected Pope as John XXI.

Public apathy plus centuries of familiarity with filth kept cutting away at the little progress, and the Black Death hit a devastating blow in the 14th century, felling 25 million persons in Europe. It is estimated that between one-fourth and one-half of the population of England died, and two-thirds of Oxford's students were victims.

Historians feel that a few rulers were aware of conditions and tried to help, despite protests from the people. They strongly suspect that the broadest hint ever recorded was the inauguration of the Honourable Order of the Bath by King Henry IV in 1399. The 46 gentlemen who were thus favoured by the king found that the important part of their initiation into the order was a good, hot bath. Ostensibly waited upon by servants during this rite, they were given no opportunity to duck the issue.

By the end of the 16th century, France, Germany and Belgium had a few isolated public inns with adjoining vapour baths, and the trend started upward. During the 18th century, the bathtub "caught on" again. Always ones to look to their beauty and to take up a fad, lovely Parisian ladies dabbled in this new vogue of personal cleanliness. Not enough to set the world a-bubble, to be sure. History still records a suspicious number of "perfumed ladies" in that period.

But the stir of interest in Europe was enough to intrigue an American patriot who, in 1778, returned triumphantly to the little fighting colonies with an incongruous duo, a treaty of aid in the revolution against England —and a bathtub!

Benjamin Franklin, famous for his many patriotic and inventive gifts to humanity, added one more—a boost for bathing. He had a popular French style, the "slipper tub," made in copper to his order and design. In the shape of a boot, it was ingeniously designed to let the cozy bather sit in the "heel" over an open grate that heated the water, tucking his own feet in the narrow "toe" of the tub.

Marie Antoinette's tub, installed at Versailles by King Louis XVI as an elegant gesture to his queen, was topped in sheer opulence some years later by Empress Josephine's special little number, hewn from a single block of white marble. This tub was the main feature of her luxurious bathroom in the Chateau Malmaison, an estate purchased as a gift for the young general Bonaparte.

With an eye more to comfort than to beauty, men, too, took sparingly to the bathtub—a trend that built a strange relationship between murder and the Muse. The world's most sensational bathtub murder, in 1793, combined the peculiar ingredients of high-style "cloak and dagger" tactics, a skin ailment and a two-franc dinner knife. Jean Paul Marat, a French Revolution leader, was accustomed to sitting in his bath to relieve an itching condition of his skin. On a July evening, he heard a member of his household admit a young woman, purportedly with an important message about his enemies, but in reality an assassin. Thus Charlotte Corday was received by unsuspecting Marat while resting in his bath. Believing Charlotte to be in sympathy with him, he spoke freely of sending her friends to the guillotine. She climaxed his threats with one thrust of a smaller, but equally effective, blade, her dinner knife.

Later, affording history a more comfortable ending to a bathtub story, the drama "L'Aiglon," by Edmond Rostand, inspired by the son of Napoleon, was admittedly written "under water." Rostand, often unable to think clearly in the sociable chatter of visiting friends, found in his bath the peace and quiet necessary to write.

Better classes of homes sported the new "chaise longue" tub, a thing of dubious beauty, indeed. In appearance like grandfather's wicker porch furniture, the length of the tub was covered with a hinged top that stood up while members of the family took turns in the single filling of water. Bang the lid down after the baths and lo! It was a piece of furniture.

The vapour bath—popular through all ages and in all countries—took various forms in the middle 19th century. Egypt leaned more toward the luxurious treatment, with white marble paved apartments. Comfort was the key, with attendants massaging customers and the bather sipping coffee and smoking, perfectly relaxed, while the soles of his feet were rubbed for about an hour.

On the other hand, the Russians, even then determined to demonstrate their toughness, evolved a more Spartan system of climbing wooden steps in a steam room to reach higher heats. This type of bath ended with the bather being "flogged" with birchen twigs. Then he was either held over a jet of ice-cold water or, if in an heroic mood, he dashed outdoors to roll naked in the snow.

The Finns developed their own combination of "public" bath-house and private bathing still in use today. The family had an outdoor sauna, a two-room structure (one for bath, one for dressing). Stones heated in a stove were splashed with cold water, causing dense clouds of steam to rise.

But centuries of European and Asiatic bathing practices were soon to be eclipsed by a suds-happy America—the most bath-conscious nation in the world today, owning (and it is to be presumed, operating) approximately 90 per cent of the tubs manufactured.

In Colonial and Revolutionary times, the family wash was whisked out of the round wood wash-tub and junior was plunked into it. In winter, the bath was an indoor affair, comfortably close to the warm fireplace. In clement weather, everyone bathed in rivers and streams.

Wealthy southern planters, whose quick tempers and fighting records kept them from being called foppish, became exceedingly fastidious about

(Concluded on page 102)

Twenty Years Ago

(From *The Canadian Hospital*, September, 1935 issue.)

"An Act Respecting Mental Hospitals and Schools", which came into force by proclamation (Ontario) on August 1st, provides, in Part IX, for the establishment of Mental Health Clinics. "The Clinics are designed to be travelling units which will be of assistance to the medical profession and to the community. Their services will consist of advising in the diagnosis and treatment of mentally ill persons in the community and in carrying on the treatment of the less severe cases not requiring to be sent to hospital".

"To get occupational therapy permanently established in hospitals and nursing homes, the physician must first be educated to its needs, then the public and the rest will naturally follow," states Ruth MacLachlan Franks, M.A., M.D., of Toronto in an article entitled *The Therapeutic Value of Occupational Therapy*.

Dr. George F. Stephens, General Superintendent of the Winnipeg General Hospital, Winnipeg, Man., has been elected by acclamation a member of the McGill University Board of Governors, Montreal, as one of the three representatives of the McGill Graduates' Society.

Dr. D. M. Robertson, President of the Ontario Hospital Association, has recently returned from a two-month tour of Europe during which he attended the congress of the International Hospital Association in Rome.

Dr. O. C. Gruner has been appointed pathologist of St. Paul's Hospital, Regina, Sask.

The Oshawa General Hospital, Oshawa, Ont., held its Silver Jubilee, August 13th. From a hospital of 16-beds, the institution has been expanded until now more than 200 patients can be accommodated. A happy and notable feature of the occasion was that Mrs. R. S. McLaughlin, Secretary of the Board of Directors and President of the Oshawa Women's Auxiliary of the hospital, Dr. D. S. Hoig, Chairman of the Board of Physicians, and Miss A. MacWilliams, Superintendent of the hospital, each has completed 25 years of service with the institution. On behalf of the Board of Directors, Miss MacWilliams was presented with a cheque and a handsome scroll outlining her excellent record as superintendent.

The Board of Directors of the Eastern Kings Memorial Hospital, Wolfville, N.S., has rented a home to accommodate the nursing staff.

Lucky Iceland

Iceland has plenty of excellent drinking water (for its sparse population of one person to the square kilometre) from springs, rivers and brooks, and it is so pure, clear and free from bacteria that no purification is needed.

More than half the population makes use of natural hot water, together with electricity from hydro-electric plants, for heating, lighting and cooking.

The many swimming pools and swimming halls use natural hot water almost entirely and it is quite free from bacteria. In most cases the quantity is so great that no recirculation is used and the hot water flows straight through.—*from "World Health Today", April 7, 1955.*

Medical Service for Eskimo Land

When the *C. D. Howe* sailed on June 25th on its annual trip to the eastern Arctic, it had aboard two medical survey teams from the Department of National Health and Welfare. Each of these teams and the three others which set out at the same time consists of a medical officer, a male nurse or hospital attendant, an x-ray technician, and an interpreter. Dentists are travelling with two of the groups. The goal is to see as many as possible of the 3,000 Eskimos in the territory to be covered.

Such teams have gone out before, but this year there was a difference. The *C. D. Howe* can touch only at the main points on the eastern Arctic coastline, and medical parties in the past tried to have Eskimos assembled at these points. This year, however, only one team is travelling with the ship, while the others go by plane, boat, or any other way available along the coast. Since most Eskimos camp along the coast in these areas it was hoped by this means to reach most camps and x-ray every Eskimo encountered, as well as to get material for registration of the population. Last year 45 per cent of the Eskimo population was reached for chest x-rays.

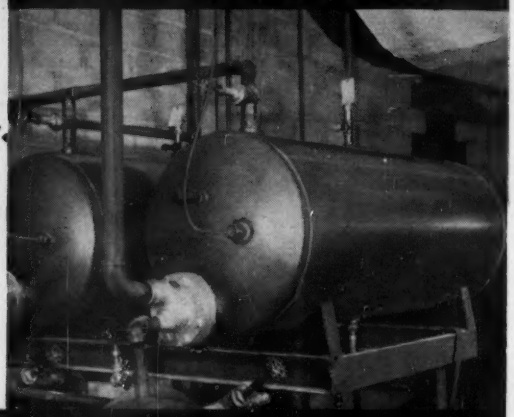
In the past x-rays were developed after the party returned home, which meant a delay, sometimes of months, in getting sick Eskimos to a hospital. This year x-rays are developed on the spot and Eskimos in need of hospital treatment evacuated immediately, travelling with the party to the nearest point from which they can be flown south.

In addition to recording vital statistics and environmental data, taking x-rays, giving immunizations, diagnosing and treating illness, and arranging for the evacuation of Eskimos who need hospitalization, the medical parties also carry out intensive health education among the Eskimos. Various visual aids, some of which were prepared in co-operation with the Northern Administration and Lands Affairs Branch of the Department of Northern Affairs and National Resources, have been used for this purpose. The teams carry film strips showing actual pictures of an Eskimo throughout his stay in a hospital, posters on the same subject, and illustrated booklets which are distributed to families, thus allaying fear and anxiety on the part of both the patient and his relatives. A film of Eskimo patients in a sanatorium is also used, and an effort is made to provide photographs of patients now in hospitals for distribution to their relatives. Elementary principals of hygiene, nutrition, and preventive medicine are stressed, and reasons for all medical procedures, such as immunization, given each patient.

PATS

Twelve high school girls in Kentville, N.S., have organized the first group of "patient assistants," or PATS, as they are called. The PATS are serving the Blanchard-Fraser Memorial Hospital in Kentville on a strictly voluntary basis by taking over many of the little jobs which take up so much of a nurse's time. They supply their own uniforms and, after a week's course on various aspects of patient care and a three-month probationary period, are capped and take an oath. The girls work during the hospital's daily busy periods.

Two Monel hot water storage heaters manufactured for the Confederation Life Building staff house. Shown during installation, tanks are 30" x 84" and have capacity of 240 U.S. gal.



Monel*

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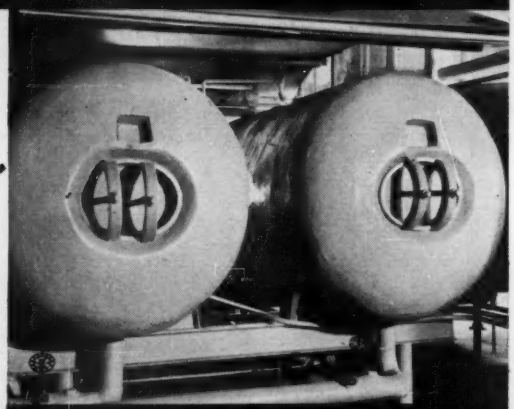
DESIGNED TO STOP COSTLY REPLACEMENTS



Two insulated Monel hot water storage heaters for Confederation Life Building, Toronto. Tanks are 42" x 120" and have capacity of 680 U.S. gal.

It is important to select hot water storage tanks that will last. This becomes obvious on consideration of the generally large size of storage tanks and the relatively cramped locations where they are usually installed. Under these conditions, replacement is all but impossible and invariably expensive.

Monel* hot water storage tanks, with their immunity to rust and high resistance to corrosion, answer the needs of long life and service . . . and, further, assure adequate quantities of *clean*, hot water for the entire life of the storage tank installation.

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Provincial Notes

(Concluded from page 72)

QUEBEC. The new, 149-bed Jeffery Hale's Hospital is now nearing completion. The site for the building, (which will cost about $3,800,000) was donated by Frank W. Ross in 1951. Founded in 1867 by Jeffery Hale as a Protestant hospital, the institution cares for patients of all faiths and denominations.

New Brunswick

CAMPBELLTON. Construction began in August on the new extension to the Provincial Hospital, the third phase in the hospital's long-term expansion program. The addition will cost about $2,000,000, and will increase the hospital's capacity from 200 to 600 beds. Completion of the project is expected early in 1957. It will provide, besides the additional ward space, kitchen and dining room facilities, an auditorium, and space for a branch of the Provincial Laboratory Service.

SAINT JOHN. A $738,000 nurses' residence is now under construction at the Saint John General Hospital and it will permit training of an additional 113 students a year. The addition is to be completed early in the new year and is part of the hospital's current $4,000,000 expansion program. A contract has also been awarded for construction of kitchen, laundry, and other facilities.

Nova Scotia

GLACE BAY. The Golden Jubilee of St. Joseph's Hospital was celebrated recently, with the Hon. Paul Martin, federal Minister of Health, officiating at the opening ceremonies. Mr. Martin addressed the 50th graduating class from the School of Nursing. A banquet, a pageant, and other events marked the three-day celebration.

* * * *

HALIFAX. Tenders have been called for the new 230-bed unit, admission building, and treatment centre to be constructed later this year at the Nova Scotia Hospital. Plans for the new building, which will cost over $1,000,000, have been under way since 1949. The architects are D. Davison and Co. of Halifax.

Newfoundland

RODDICKTON. Construction on a new cottage hospital in the White Bay area began recently and is expected to be completed this year. The hospital, which is being built by the International Grenfell Association, will accommodate 12-15 patients. It is understood that the hospital is being built with lumber imported from Bridgewater, Nova Scotia.

* * * *

ST. ANTHONY. St. Anthony Hospital, operated by the International Grenfell Association, recently added a new aircraft to its facilities. It will be based at St. Anthony and will operate under the direction of Dr. Gordon Thomas, Medical Officer-in-Charge.

Coming Conventions

Sept. 17-19—Annual Meeting of the American College of Hospital Administrators, Traymore Hotel, Atlantic City, N.J.

Sept. 19-22—Annual Meeting of the American Association of Hospital Consultants, Atlantic City, N.J.

Sept. 19-22—American Hospital Association Convention, Atlantic City Convention Hall, Atlantic City, N.J.

Sept. 27-29—Annual Meeting of the Canadian Association of Medical Record Librarians, Halifax, N.S.

Oct. 9-10—Catholic Hospital Conference of British Columbia, St. Vincent's Hospital, Vancouver.

Oct. 11-14—British Columbia Hospitals' Association Convention, Vancouver.

Oct. 18-20—Annual Meeting of the Associated Hospitals of Manitoba, Winnipeg, Man.

Oct. 23—Annual meeting of the Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 24-26—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Annual Meeting of the Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask.

Oct. 27-28—Annual Meeting of the Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

Oct. 29-31—Annual Meeting of the Canadian Association of Occupational Therapy, Toronto, Ont.

South African Studies Hospital Aid Policy Here

Dr. J. J. S. Wassenaar, a member of the provincial council of the Transvaal, South Africa, recently made an unofficial study of Ontario's policy on financial aid to hospitals. His province's experience with hospital plans has been most unsatisfactory from a financial viewpoint, he said.

The Transvaal has had a government-sponsored hospitalization plan since 1948 which provides free beds, food and nursing for both Negroes and whites. The cost of the plan, Dr. Wassenaar said, has increased 10 times since it was instituted and last year meant an expenditure of $27,000,000 by his province. One reason why hospital costs increased so much is because many of the hospitals have become, in effect, convalescent homes for people who would not stay in the hospital if they had to pay the cost themselves.

Only uncultivated people find good manners formidable. Courtesy is kindness expressed in action, and etiquette is merely a collection of forms that help to make courtesy easy and natural.

Business Office

(Concluded from page 60)

bookkeeping machine is done in the main business office by a bookkeeping machine operator.

Equipment in the payroll office consists of a desk and chairs, a fire-proof safe, ledger tray with castors for storing the active employee earning records, a set of document files for storing time cards, a letter-size filing cabinet for storing payroll files, and a printing calculator.

Conclusion

We feel that our accounting system and routines are as streamlined as in most offices; however, there is always room for improvement.

Machine accounting has many advantages. As a rule it prepares several records in one operation. It is accurate and neat. It requires fewer employees and less space than would be required for hand operations. We have mechanized as many procedures as we feel are economical and are thus able to operate in a relatively small space with a small staff. As volume increases, we may find it necessary to utilize our bookkeeping machines for other work. We would suggest that mechanization of a hospital's accounting procedures can be at least a partial solution of the space problem which so often confronts the business department.

Bath

(Concluded from page 90)

their appearance and elegant apparel. They took to using metal-lined tubs exclusively designed for personal bathing.

The young nation was quick, too, to connect cleanliness with health. Benjamin Franklin, who had created his own stir with a bathtub, put Philadelphia in the forefront as a devotee of the Saturday night session. By 1820 bathtubs actually appeared in Philadelphia advertisements, and by 1837 there were 1,530 home owners who had surrendered to the lure of the early copywriters who had hit upon a theme of personal cleanliness that was to be the making of America's great soap industry.

Still, lack of adequate piping and sewerage systems made the bath a chore instead of a pleasure. Even the wealthy, such as Nicholas Biddle, president of the United States Bank, who was reputed to have installed a Carrara marble tub in his Philadelphia home in 1825, needed a corps of assistants to get the job done. Servants carried in heated water; a hole in the bottom of the tub attached to a drain hanging out the window carried the water down the wall of the house—an ignominious conclusion to a bath in a marble tub!

(to be concluded)

Book Reviews

(Concluded from page 78)

supplemented these in some instances himself. This book will be of value to administrators and purchasing agents as it contains much of the latest and best thinking on the problems of hospital purchasing compressed into one volume. The material is presented in an attractive manner, readily available for reference, and many sample forms are included.

Their joint account's retarded
By one persistant flaw
He's fast on the deposit
But she's quicker on the draw.—
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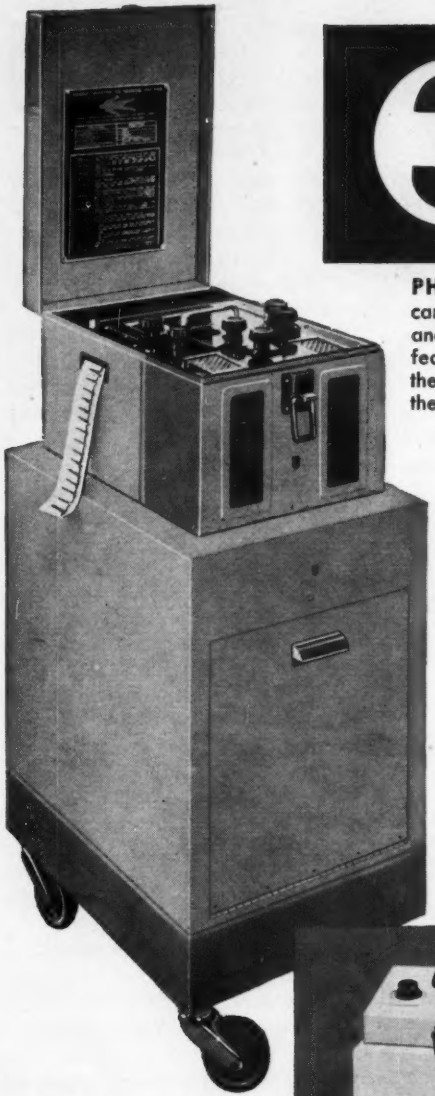
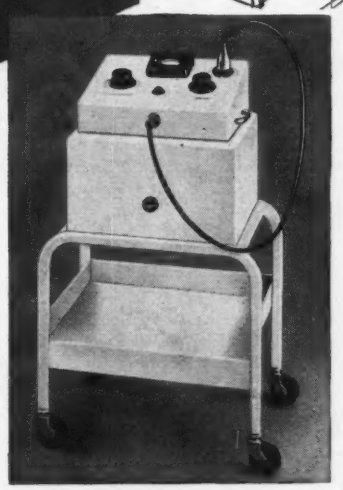
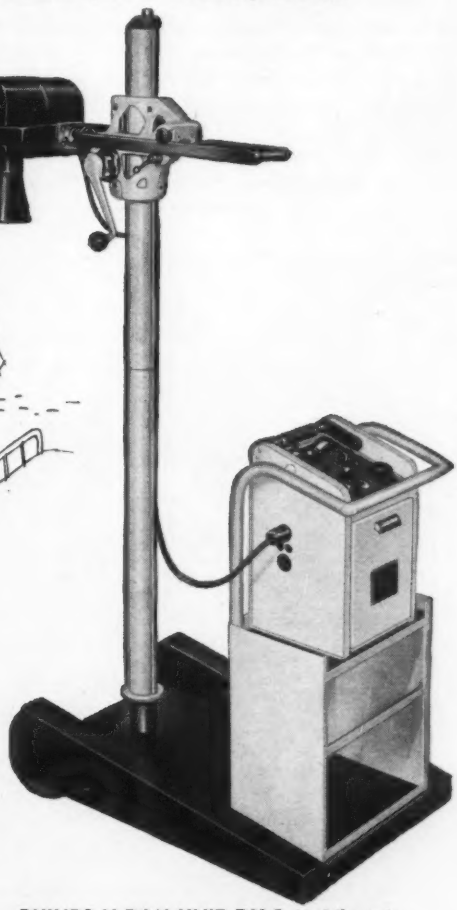
3 indispensable units

PHILIPS CARDIOLUXE Here is a portable, direct writing electrocardiograph that represents the very latest developments in both function and design. Practically eliminates A.C. interference. Philips Cardioluxe features instantaneous record, clear definition and extreme fidelity under the most adverse conditions. Its compactness and ease of operation makes the Cardioluxe suitable for both heart specialists and hospital staff.





MEGASON — ULTRASONIC UNIT This modern physiotherapy unit incorporates these features:— single knob control, direct reading meter, continuous dosage accuracy, automatic treatment timer and a natural grip transducer. Sturdily constructed for years of wear.



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Saskatchewan's First Hospitals

The first nursing services in the province of Saskatchewan were offered as early as 1860 by a tiny Indian mission called Ile-a-la-Crosse, 400 miles north of Saskatoon. Here the Grey Nuns, founders of the mission, did nursing among the children they taught and dealt with any epidemic that appeared among the Indians.

Next to be established were two military hospitals at Moose Jaw and Saskatoon. Set up to take care of the wounded from the Riel rebellion in 1885, they were hastily prepared establishments, but staffed with trained nurses. In charge of the Moose Jaw hospital was Mother Hannah of the Anglican Order of St. John the Divine. Three members of the sisterhood and three graduate nurses from the training school of Bellevue Hospital, New York, N.Y., made up her staff. Nurse Millar and a group of nurses from Winnipeg General Hospital staffed the Saskatoon base hospital. Working under the most primitive conditions, these nurses managed to provide satisfactory care for the wounded of the rebellion.

It was not until 1898 that the first permanent hospital was established in Regina. Instrumental in establishing this cottage hospital was the Local Council of Women, organized in 1895. Raising funds by all means at their command, they worked tirelessly, materially aided by a contribution of $1,500 from the Victorian Order of Nurses, who also supplied hospital staff. Called the Regina Victoria Hospital, it became the General Hospital in 1901, and was taken over by the city in 1907.

Meanwhile the Victoria Hospital was established at Prince Albert, much of the financing being done by the Ladies' Aid, who collected both in coin and in kind. This was begun in 1899. Immigration was rapid now, and new hospitals arose with the need for them.

Some of the immigrants, arriving in groups, brought their own doctors and nurses with them. Among these were Doukhobors from Russia, 7,500 of them arriving in 1898. The medical care was hardly adequate for this number, however, consisting of one doctor and five nurses. The Barr colonists were even worse off, for although they were promised medical care and hospital insurance under their immigration scheme, they found that no provision for either had been made.

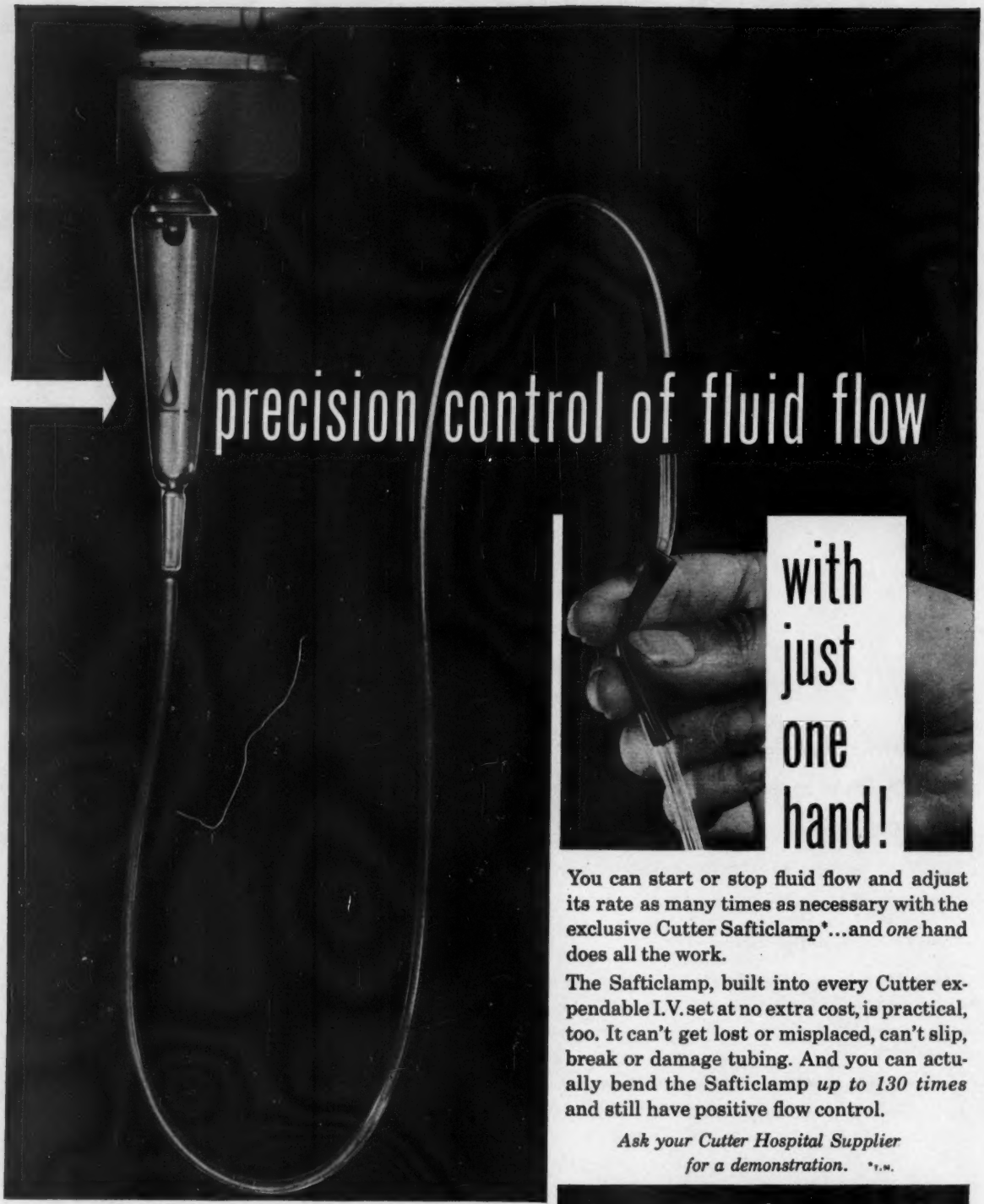
Of first importance in caring for the flood of immigrants was the Victorian Order of Nurses. Deluged with requests for cottage hospitals, they responded nobly with contributions of cash and staff. With their aid, cottage hospitals were established in Yorkton, Maple Creek, and Indian Head.

In 1906 the public hospital in Moose Jaw was opened. In the same year a typhoid epidemic which struck Saskatoon resulted in the opening of a small temporary hospital in the rectory of the parish priest of St. Paul's parish. This continued and grew into the present St. Paul's. The following year the Grey Nuns' Hospital was established in Regina.

Both Protestants and Catholics worked ceaselessly for the extension of hospital facilities. The Women's Missionary Society of the Presbyterian Church in Canora established a hospital there in 1907 which is still active. Among the Catholic hospitals one of particular interest is that established by the Sisters of St. Elizabeth (from Klagenfurt, in the Austrian Tyrol) to care for members of a Catholic German group of homesteaders situated around Humboldt and Muenster. Three Sisters reached Muenster in 1911 and three others in 1913, and established the St. Elizabeth's Hospital in Humboldt which is still in operation. In the following year small general hospitals were established at Swift Current and Weyburn. — *Wolseley, Sask., "News."*

Moving Up

In 1895, Charles D. Seeberger coined the word "escalator" to describe his moving stairway. The word was likely derived from the Latin word "scala" meaning ladder. In 1898, the first moving stairway was set up and when it was moved to France to be exhibited at the Paris Exhibition of 1900, it was labelled Escalator.



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Perfect Cast – *after 3 weeks' hard wear!*

THE BANK MANAGER of a small town fell and suffered a Colles fracture. Here is the Gypsona cast which was removed three weeks later. The thin, even formation is a characteristic of a Gypsona cast. This thin, light cast is made possible by the high plaster content of Gypsona which gives exceptional strength and makes it the most economical plaster of Paris bandage.

The clean, porcelain-like appearance of the cast, still intact after three weeks' wear, is further evidence of the quality of the fine ground Gypsum and the high content of this remarkable bandage.

Gypsona
TRADE MARK
PLASTER OF PARIS BANDAGES

Gypsona bandages are made by SMITH & NEPHEW LTD., Hull, England

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2285 Papineau Avenue, MONTREAL 24, Que.

Pharmaceutical Services

(Continued from page 56)

internship program in hospital pharmacy for students who have completed their undergraduate training. It will be some time yet before such a program can be introduced but it is felt that this is the type of training required for the qualification of students in hospital pharmacy.

It is quite evident that the educational facilities of the Department of Pharmaceutical Services are best suited to the training of hospital pharmacists. Yet it would be unfortunate if the educational potential of this department was limited to the relatively small group who chose to practise their profession in hospitals. The activities of hospital pharmacy are so varied that all students may benefit from their association with the pharmacy department of the University Hospital. The facilities of the pharmacy will be used for training undergraduates as part of their regular laboratory course in dispensing. Such training will be of value to all students of pharmacy and will ensure that no student will graduate from our college without having filled an actual prescription.

The manufacturing laboratory will also be available to provide training of a practical nature for those students wishing to specialize in industrial pharmacy. Although manufacturing will only be done on a pilot plant scale, many of the basic principles and problems of commercial production can be demonstrated.

The department also participates directly and indirectly in nursing and medical education. Lectures in pharmacology are given to the students of the diploma class of nurses by members of the pharmacy staff. The director of the department, through his association with the College of Pharmacy, participates in a series of lectures on prescription writing to the second year medical students.

Education on a formal or informal basis is a function of any hospital pharmacy. Because of the very nature of a university hospital, this function is of particular importance to its pharmacy department.

As previously mentioned, Central Supply Service has been made a responsibility of the Department of Pharmaceutical Services. The principle object of combining these services is to relieve the Department of Nursing Service of some of the detailed administration so that they might have more time to devote to the direct care of the patient. To date this arrangement has proved most satisfactory.

Central Supply

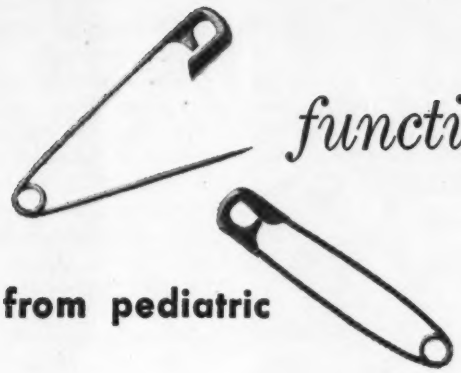
The function of Central Supply Service is to store, maintain, prepare and deliver all sterile supplies, trays and equipment used in the hospital with the exception of the instruments used in the operating rooms. A number of unsterile pieces of equipment such as compress heaters and vaporizers are also kept in Central Supply.

In working out supply procedures for this service, the emphasis again has been placed on delivering the supplies to the nursing units and to remove, as much as possible, the necessity of nursing personnel having to leave the floors to obtain equipment. Frequently used trays and supplies are delivered routinely throughout the day without requisitions. Special trays and equipment not included in the routine delivery service are requisitioned by pneumatic tube and are sent up on the

(Concluded on page 110)

WOOD'S SALESMAN
Wins Champion Steer

George Ayotte, Quebec City, receiving the 1,500 lb. Steer from Geoffrey H. Wood, President and General Manager of G. H. Wood & Company, Limited, at Toronto, which he won as top salesman in the Wood's "Sky High" nine-week, Coast-to-Coast Sales Campaign. Mr. Ayotte also received a large silver trophy cup, filled with shining new silver dollars.



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Magnolax provides effective, economical and highly acceptable laxation for the bedridden patient in whom constipation is so frequently a problem. Just as the safety pin, the axe or the oar are functionally correct and have never been improved upon, Magnolax is functionally correct in the management of constipation.

MAGNOLAX is an emulsion of milk of magnesia and liquid petrolatum with a pleasant vanilla flavor. Contains no sugar or fats.

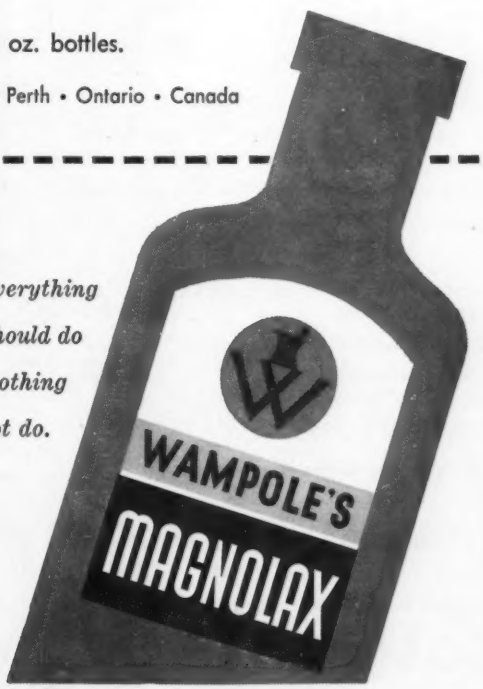
Will do . . . Buffer hyperacidity . . . provide gentle intestinal lubrication and physiologic peristaltic stimulation . . . produce a soft stool

Will not do . . . leave oily taste . . . cause anal leakage, habituation, griping or watery stools

Available: In 8 oz. or economical 20 oz. bottles.

Henry • K • Wampole & Co. Limited • Perth • Ontario • Canada

Magnolax® . . . *will do everything a good laxative should do and nothing a good laxative should not do.*



Pharmaceutical Service

(Concluded from page 108)

dumb-waiter or delivered by Central Supply personnel.

The success of the Central Supply operations to date is due primarily to the efforts of the supervisor, Betty Sellers, R.N., and her assistant, Mrs, J. Muir, R.N. In less than one year they have organized the service, developed their procedures, and trained a staff of 20 Central Supply assistants, many of whom had never worked in a hospital before. It has been a most creditable performance indeed.

The space allocated to Central Supply Service has been divided into a number of areas to facilitate the orderly flow of materials through the necessary preparatory procedures. Used and contaminated equipment is cleaned in a receiving room and passed along to the main work area where it is stored for future use or made up into trays or packs. The trays and packs, after being assembled and checked in the main work area are passed along to the sterilizing oom where they are autoclaved. The now sterile supplies are stored in a sterile storage room and are ready for delivery to the nursing stations and operating rooms. Two small rooms have been provided, one for the preparation of gloves and the other for cleaning and sharpening needles.

Central Supply Service also includes an oygen therapy section which maintains and delivers oxygen and suction equipment to the various wards and departments of the hospital. The orderlies of the oxygen section are also responsible for the periodic checking of tent atmospheres and the general condition of the equipment in use.

The Department of Pharmaceutical Services has now completed its first five months of operation which has been in the nature of a shake-down period. Much remains to be done before we will be completely organized and operating at peak efficiency and no doubt many changes and modifications will be necessary. However, it now appears that the basic planning has been sound and we are eagerly awaiting the day when we will be operating at full capacity.

He is one of those wise philanthropists who in a time of famine would vote for nothing but a supply of toothpicks. — *Douglas Jerrold*

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A FINE HOSPITAL DEMANDS THE BEST!

Eaton's is happy to have shared in planning and supplying furniture and furnishings for the new University Hospital.

In the magnificent new University Hospital, not only advanced scientific equipment but the charm of restful, attractive surroundings have been provided to speed the patient's progress.

The Hill-Rom recovery beds and the Hill-Rom Hi-Low motorized beds in use are available in Canada only through Eaton's, and they contribute immeasurably to the comfort of the invalid and convenience of attending physicians and nurses.

Eaton's was responsible, too, for most of the furniture and furnishings in all the Public Rooms and in the Nurses' Residence—an achievement consistent with our twenty-five years' leadership serving hospitals across Canada.

The new University Hospital, one of the finest in the Canadian West gives Saskatoon and all of Canada just reason to be proud. May it flourish long in its great service to humanity.

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THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

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Early Prepaid Hospitalization Plan

When a log shack was torn down in Lashburn, Saskatchewan, during the summer, evidence of an early voluntary prepayment hospital plan was found. Among other papers, there was a receipt headed Lashburn Cottage Hospital which entitled one Mr. H. I. Hill to "three weeks treatment in public ward in above hospital within twelve months from date of this receipt." It was dated September 23, 1909. The hospital, predecessor of the present Lashburn and District Union Hospital, was established in 1907. The faded receipt is among papers displayed at an exhibition, sponsored by the South Lashburn Homemakers, as part of their jubilee celebrations.

Security

In the world in which we are living to-day, a world where science and economic necessities have broken down frontiers and are bringing nations and individuals closer together, where prosperity is as indivisible as peace, there is a risk that inequalities may cause fearful disturbances and complications. In fact, only if liberty, equality and justice are respected will security be assured.—*Vincent Auriol.*

DOMINION LINOLEUM

...resilient quiet, modern flooring for the modern hospital

Dominion Jaspé Linoleum Tiles provide appealing flooring for the Lounge of the new Allan Memorial Hospital in Montreal.

Discerning architects and builders are selecting a proven product —Dominion Linoleum—to provide beautiful, long-lasting, completely appropriate flooring for Canada's striking modern hospitals, schools and churches.

Dominion Linoleum has proven itself to be the best product in its price range. It is the *only* modern resilient flooring with a fifty-year "pedigree" of product excellence—a pedigree *earned* by its top performance over the years. It has demonstrated its durability... proven easy and economical to maintain, simple and economical to install. It has also shown outstanding *resilience* —it cushions footfalls, hushes sounds. This record is responsible for the installation of Dominion Linoleum in large areas of the new Montreal General Hospital—it was selected because it gave completely satisfactory service in the *old* Montreal General for *fifty years!*

Dominion Linoleum offers still another advantage—a wide new range of quietly-beautiful colours. These soft shades are being used to create distinctive, eye-pleasing flooring designs in the attractive hospitals of today.

For samples, further information, write to: Dominion Oilcloth & Linoleum Co. Ltd., 2200 St. Catherine St. E., Montreal.

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COMES IN TILES AND BY-THE-YARD IN THESE FOUR TYPES...

✓MARBOLEUM ✓DOMINION JASPÉ

✓HANDICRAFT ✓DOMINION PLAIN

... all available in "Battleship" quality

The Lucerne Congress of the I.H.F.

(The following excerpts are taken from a report on the International Hospital Federation Congress held last spring in Lucerne, Switzerland. The report is contained in the "News Bulletin" of the I.H.F.—Edit.)

The end of a congress is only a beginning. Its value is to be measured by its longterm results; by the action taken by participants, on their return home, to give effect to its conclusions.

What were the conclusions of the Lucerne Congress? All the papers presented and all the ensuing discussions brought to light a fact of vital importance, not only for the hospitals themselves, but also—and above all—for the people who come to the hospitals for treatment: the fact that the patient is at last coming into his own. The tendency to subordinate the patient's interests to the efficiency of the hospital and the comfort of the staff is giving way to a desire to place the patient in the centre of the whole hospital organisation and to focus all attention and effort on him. Members of all the branches of hospital staffs — in particular doctors, nurses, administrators, almoners and chaplains, as well as architects and others responsible for hospital planning, declared that the patient must be their sole and constant concern.

At earlier hospital congresses a large number of problems were discussed, but they were approached mainly from the point of view of the hospital, its organisation and administration. On this occasion, each of the problems under consideration was studied from the point of view of the patient, his reactions, and his well-being.

It is now an accepted fact that physical and mental well-being are inseparable. Physical recovery is dependent upon mental well-being and the efforts made to cure the patient must include every possible means of giving him a feeling of security and protecting his personal integrity. The patient must be able to see the hospital as a second home, where he will find both relief from suffering and the atmosphere of confidence and mental comfort which, at this critical moment in his life, he needs more than ever. From the moment he enters the hospital he must have the sure knowledge that his personality, his intellectual and emotional freedom, his philosophical and religious beliefs will be scrupulously respected. The people of Milan, according to one of the principal speakers, Father Gemelli, Rector of the University of the Sacred Heart in Milan, call the hospital "Ca Grande", the big house, a second home for everyone. This is the ideal towards which everyone in the hospital world must strive, so that the patient can really come into his own.

New Officers of I.H.F.

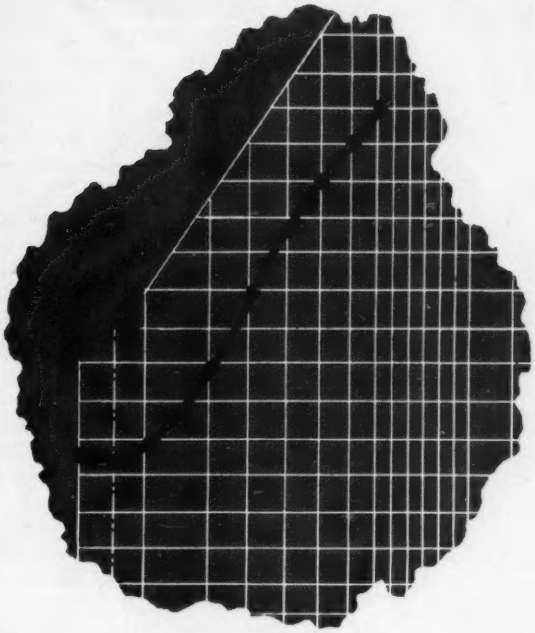
The new president of the International Hospital Federation, elected at the group's congress in Lucerne last spring, is Avv. Luigi Colombo. Mr. Colombo is also vice-president of the F.I.A.R.O. (Italian Hospital Federation) and president of the Milan Hospital Council. The two vice-presidents elected are Dr. O. Binswanger, past president of the federation and president of the V.E.S.K.A. (Swiss Hospital Association), and Dr. R. de Cock, president of the Belgian Hospital Association and a member of the former Council of Management. Captain J. E. Stone of England was re-elected Honorary Secretary and Treasurer. All the above officers were elected by unanimous vote of the Council.

The B.P. and the Metric System

The Pharmacopoeia Committee of the General Medical Committee has accepted the recommendation of the *British Pharmacopoeia* Commission that the apothecaries' system of measurement be abandoned in the 1963 *British Pharmacopoeia* and subsequent editions. It was in 1951 that the committee on weights and measures of the Board of Trade recommended, *inter alia*, that the apothecaries' system of measurement should be abolished after five years and be replaced by the metric system. The *B.P.* Commission accepted the recommendation and agreed that the apothecaries' system should be abolished from the *Pharmacopoeia*, but they feel that the earliest appropriate date for the change is the year in which the 1963 edition is due for publication.—*C.M.A.J. July 1st. in "London Letter."*

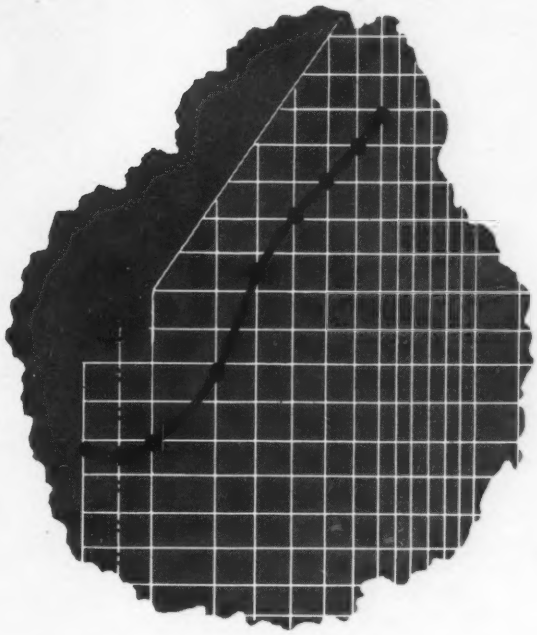
"God must be fond of ordinary people," said Abraham Lincoln, "or He wouldn't have made so many of them."

S-M-A FED



Typical growth curve of S-M-A fed baby Schematic Section on Wetzel Grid

BREAST FED



Typical growth curve of breast fed baby Schematic Section on Wetzel Grid

. . . The growth patterns of S-M-A and breast fed babies are very much alike. Clinical studies have shown that development traits, including height and weight, are parallel —and often identical—for S-M-A and breast fed babies. This may be expected because the nutritional qualities of S-M-A satisfy infant requirements essential for sound, sturdy growth.

S-M-A Powder—tins of 1 pound

S-M-A
POWDER

Wyeth
Registered Trade Mark
WALKERVILLE, ONTARIO
WINNIPEG - MONTREAL

Comité de Comptabilité

(Suite de la page 66)

future du manuel. Un certain nombre de changements mineurs dans la présentation et la phraséologie du manuel furent notés afin d'être incorporés dans la prochaine reimpression.

Il y eut une discussion poussée sur la nécessité d'inclure dans le manuel des directives au sujet de la préparation des rapports financiers et statistiques requis par les divers départements provinciaux de la santé et le Bureau Fédéral de la Statistique. Il fut finalement décidé que le manuel et le livre d'instructions publié par le Bureau Fédéral de la Statistique devraient être préparés le façon à se compléter. Le Comité suggéra d'étudier, la possibilité d'incorporer le livre d'instructions comme un chapitre du manuel.

Des notes considérables sont en voie de préparation pour cette assemblée et seront mises à la disposition du Conseil des Directeurs et de ceux qui sont intéressés au manuel.

Quoique la plus grande partie de cette réunion fut consacrée à l'étude du manuel, les sujets suivants, parmi d'autres, furent aussi discutés: (a) un cours de comptabilité par correspondence pour le personnel des hôpitaux; (b) la valeur des instituts de comptabilité dans l'éducation du personnel hospitalier; (c) un rapport financier standard pour les administrations.

Les dépenses et frais de voyage des membres présents furent absorbés par les organismes qui les avaient délégués. A ce propos, les frais de transport des représentants des hôpitaux furent partagés sur une base égale entre les différents organismes.

Ce Comité permanent ne s'est pas réuni depuis la dernière assemblée biennale.

Recommandations du Comité pour l'Avenir

Comme résultats de ses délibérations, le comité proposes:

(1) Qu'aucune revision majeure des principes énoncés dans le manuel et de sa présentation soit faite et que seuls les changements mineurs suggérés soient inclus dans une réédition immédiate du texte.

(2) Qu'une étude plus approfondie soit entreprise des possibilités d'un cours par correspondance avant de procéder à son organisation et à son dévelopement. L'opinion fut exprimé qu'une enquête devrait être faite pour se rendre compte de la demande qui pourrait exister pour ce cours.

(3) Qu'on continue à encourager la tenue d'instituts de comptabilité étant donné qu'on s'est rendu compte que c'était une manière très satisfaisante de faire connaître les méthodes comptables préconisées par l'Association.

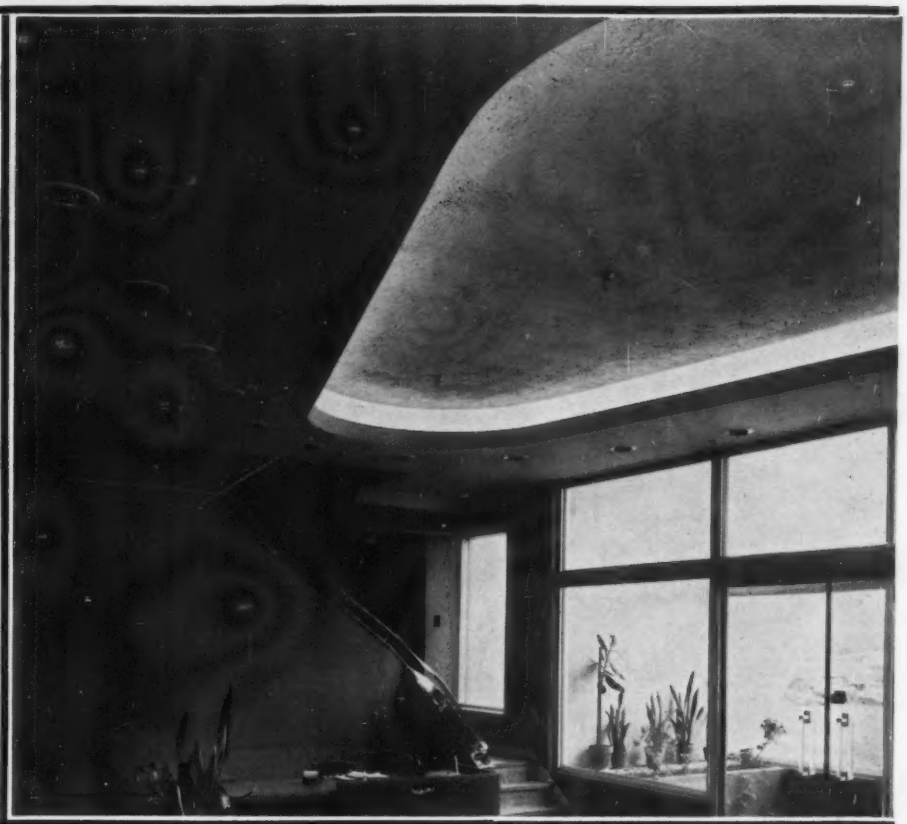
(4) Qu'on devrait appuyer sur le fait que le but de la comptabilité est de servir avant tout l'administration de l'hôpital avant d'être simplement un moyen de préparer des rapports gouvernementaux.

(5) Que l'Association des Hôpitaux du Canada considère la possibilité d'établir un département de recherches dans le but de recueillir les statistiques financières courantes des hôpitaux et de les interpréter pour le bénéfice de ses membres. Il est fort possible que ce travail devrait être fait sur une base provinciale ou régionale.

(6) Que le prochain comité de comptabilité et de statistique étudie la

(Suite à la page 118)

Quiet always makes a grand entrance!



Quiet lends dignity and distinction. In the attractive lobby pictured, the Johns-Manville Permacoustic Ceiling is a major reason for the quiet atmosphere that greets and impresses every visitor to the Head Office of Steinberg's Limited, Montreal.

Architectural Design:
STEINBERG'S LIMITED
ARCHITECTURAL DEPT.

Installed by:
J-M ACOUSTICAL DEPT.

Johns-Manville

ACOUSTICAL CEILINGS

reduce disturbing noise at low cost

UNNECESSARY NOISE has a high cost. It reduces efficiency of employees and discourages customer patronage. For these reasons, most building specifications today include acoustical ceilings for sound absorption.

But because your present building dates before the age of scientific sound control is no reason you have to put up with noise handicaps. You can have Johns-Manville Acoustical Ceilings installed over old ceilings. And to the immediate improvement in sound control is added the marked attraction of a handsome new ceiling!

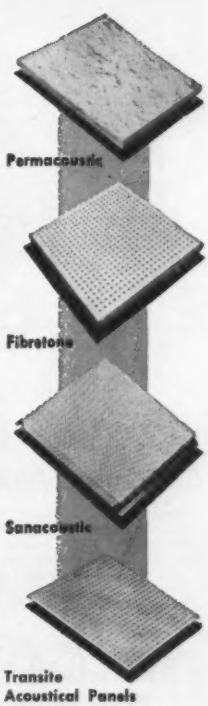
For over 40 years Johns-Manville engineers have developed acoustical materials and studied their proper methods of applications. In most parts of Canada we have expert staffs to make recommendations and installations. For details, or for free book on "Sound Control", write Canadian Johns-Manville, 565 Lakeshore Road East, Port Credit, Ontario.

Permacoustic Units provide a textured panel with outstanding architectural appeal. Specially suitable for executive offices, board rooms etc. Efficient, decorative and non-combustible.

Fibretone Acoustical Units are moderate in cost, yet they effectively combat unnecessary noise. This drilled fibre board brings the cost of sound control within reach of almost anyone.

Sanacoustic Units are perforated metal panels backed up with fireproof sound-absorbing elements. Units may be washed repeatedly, or painted without decreasing their acoustical efficiency.

Transite perforated asbestos-cement panels are especially resistant to fire and moisture. Transite Panels are highly recommended for broadcasting studios, auditoriums, laboratories.



Johns-Manville

A-432

40 years of leadership in the manufacture and installation of acoustical materials

Comité de Comptalulité

(Suite de la page 116)

possibilité de préparer un rapport financier idéal pour l'administration.

Nous avons dit que la comptabilité était une "bonne chose" pour les hôpitaux. Si tel est le cas, on pourrait s'attendre que l'administration des hôpitaux soit anxieuse d'adopter un système de comptabilité uniforme. Cependant, les humains étant ce qu'ils sont, toute chose nouvelle doit leur être "vendue" même si cette chose est bonne pour eux; le personnel des hôpitaux ne fait pas exception à la règle. Il appartient à nous tous qui sommes intéressés dans les hôpitaux de profiter de chaque occasion, comme l'a dit le Docteur Cameron, d'introduire dans l'administration de nos hôpitaux des méthodes d'affaires qui ont fait leur preuve. Je suis assuré que pas un ici présent s'opposera a l'adoption du manuel de comptabilité uniforme recommandé par l'Association Canadienne. Des associations commerciales dont les membres poursuivent un but lucratif et qui sont fièrent de leur rendement ont employé avec profit la comptabilité uniforme. Nous demandons ici l'adoption de la comptabilité uniforme pour le bien de tous — l'hôpital et le patient.

Les responsabilités de ce comité ont maintenant pris fin. Nous voulons exprimer notre gratitude pour le support enthousiaste que nous avons reçu de toute part. Le Comité est tout particulièrement reconnaissant à M. Murray W. Ross, assistant-directeur de l'Association des Hôpitaux du Canada, de son précieux concours.

A titre de président, je désire remercier les membres du Comité qui ont si généreusement donné leur temps et leur talent afin de promouvoir le perfectionnement des méthodes comptables dans nos hôpitaux.

Iceland's Hot Water

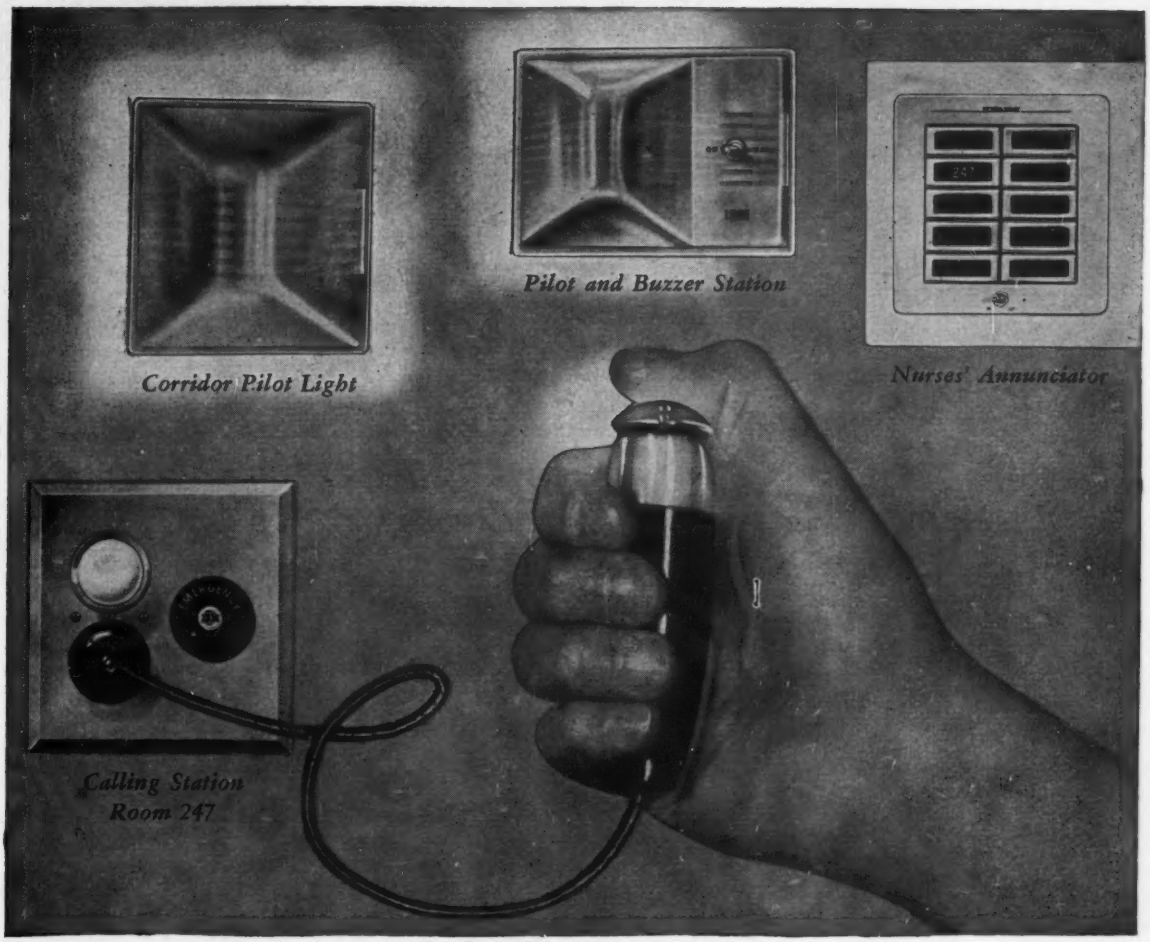
In rural areas in Iceland, springs of hot water are used for heating individual houses, schools, public buildings, swimming pools, et cetera, but in three cases towns have built a district heating system in which water from hot springs is used. The oldest and largest is in Reykjavik.

It has been operated for 20 years and now furnishes heating for 3,200 houses (two thirds of the total number) in the capital.

The water is so clean that it corrodes neither concrete nor iron and can be use even in cooking. The temperature of the water reaching the houses through the insulated pipelines is from 75 to 80 degrees C.— *from "World Health Today", April 7, 1955.*

"Should Your Child be a Nurse?"

A booklet entitled "Should Your Child be a Nurse?" is one of a series of career promotions sponsored by the New York Life Insurance Company as a public service. Among the other careers in this promotion are teaching, medicine, journalism, law and public service. Nursing is the first profession for which the spokesman has been a woman. Reprinted from a two-page advertisement which appeared in February in *Colliers, Saturday Evening Post,* and *Ladies' Home Journal,* the booklet is available in quantity from the New York Life Insurance Company without charge.



When a Patient Signals...

When a patient signals by pressing the Nurses' Call Button, the IBM System goes into operation quickly and efficiently.

A signal lights on the patient's own calling station, assuring him that the system is functioning. Simultaneously the corridor pilot light over the room door is illuminated, as well as the pilot and buzzer stations located in diet kitchens and utility rooms. The number of the patient's room is lighted on the Annunciator at the Nurses' Day Station, indicating to the nurses which room has registered a call.

The new IBM Locking Button has a luminous glow which enables the patient to find it easily at night. It is light, attractively designed, and is protected against accidental resetting.

For more information concerning the IBM Nurses' Call System and other IBM Systems for hospitals, write to the address given below.

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HOSPITAL SIGNALING AND COMMUNICATING SYSTEMS

Time Recorders and Electric Time Systems • Proof Machines • Electric Punched Card Accounting Machines Service Bureau Facilities • Electric Typewriters

INTERNATIONAL BUSINESS MACHINES COMPANY LIMITED

Head Office: Don Mills Road, Toronto 6

Prepayment Health Plan

(Continued from page 64)

of health care. If we of today can do no better for those who come after us than to provide them with a system of health care that by its very nature will deteriorate, then ours is the shame and ignominy of failure.

From study of the past ten years' experience here in the Maritimes, certain conclusions have forced themselves on my own personal thinking. My opinions on certain phases of health care have altered with the passage of time and the force of new knowledge. In the field of prepaid hospital care certain conclusions would seem to face us with a reality that demands immediate solution. First and foremost is the realization that, despite the fact that hospitals must remain ever open to those in need, they are nevertheless business institutions and must be run on business principles. Cost accounting, and I mean adequate cost accounting, is a must if hospitals are to survive. Costs and charges must be placed where they belong. It is, I am afraid, no longer feasible nor desirable to provide services to anybody for less than an adequately controlled cost to the hospital. Adequate salaries, commensurate with those in other fields of endeavour, must be faced by hospitals and the charges passed on to those utilizing the service. If increased costs are due to bed and board they should not be assessed against the professional side of health care. Changing economic conditions, altered work hours and work weeks are rapidly forcing us into a situation where hospital facilities, except for emergencies, are not available at all times. The community therefore must pay more for health care and it is up to us to do something about it. At present-day hospital cost levels, we cannot afford to have our patients lying in bed awaiting investigation or curative measures or procedures. We must devise with our medical confrères newer and better methods of giving rapid and efficient work-ups. We must gear our institutions to handle peak loads just as efficiently as standard loads. We must give the same high level of service with our 36- or 40-hour work weeks as we did when everyone worked longer hours. More adequate leisure for our staffs is the heritage of our new economy. I do not promise to the professional people in the hospital and

medical field that they will reap the benefit of this added leisure, nor perhaps will they be rewarded to the extent that they would feel entitled to in remuneration or financial return, because ease and facility of providing health care have never been incentives to the professions which we still feel belong to a nobler human endeavour.

Ancillary Services

Thirdly, we must undertake a complete study and reorientation of our thinking with regard to what we now know as ancillary services. X-ray, laboratory, pharmacy, physiotherapy, physical medicine, all these arts and sciences today must be provided with facilities at a cost more realistic in the light of today's findings. Now, without entering into the controversial problem of whether hospitals are practising medicine and whether they are making money out of doctor's professional services, let me simply admonish you that you face this issue, fearlessly, honestly, and with malice towards none. It is my firm personal conviction that if a medical director of any department offering ancillary service is adequately recompensed for his services, and if a hospital is then making profits out of proportion to those which standard accounting and proper operation of that department demand, the only answer is that the charges made by the hospital are excessively high and should be brought down to a reasonable level in justice to the patient. I see no force in the argument that profit must be made on ancillary professional services to compensate for losses in other departments. If a profit is made on ancillary services and applied to other departments of the hospital, then we are defeating one of the most formidable and potent weapons of health care because ancillary services are primarily diagnostic aids and therapeutic adjuncts in the majority of cases. We are setting back the advent of bigger and better and more adequate diagnostic services by keeping the charges for these services at a level which prevents their more wide-spread application.

Specifically, if our charges for x-rays are out of proportion, then we are preventing a more widespread use of our x-ray departments, out-patient and diagnostic services. If our laboratory services, whether run by government agencies, hospitals, or pri-

(Concluded on page 122)

Prepayment Health Plans

(Concluded from page 121)

vate companies, cost the community too much, either because of lack of co-ordinated effort, poor utilization of personnel, or for any reason whatsoever, then we must find a way of making these services available to the public at lower cost. Business has managed to bring more and better products to the public at less cost. They have cut red tape, streamlined production, sale, and delivery of goods, and developed a volume that delivers a better article at a cheaper price and with a smaller margin of profit. The time has come for us to ask business, if necessary, how to do the same with our ancillary and other services.

Cost of Medical Care

If better hospital care is provided at lower cost, medical care will, I feel certain, adjust itself to this new economy. Medical fee schedules and charges have in the past been based on the patient's ability to pay and on the small percentage of collections made for such services, the field of prepaid medical care is now opening up a new era of thinking. With more and more people being covered through medical prepayment plans, with volume payments increased, the cost of medical care to the community is actually coming down. People are living longer with more and more preventive medicine; the health dollar is buying more and more while the commodity dollar is buying less and less. Never in the history of this country have more efficient health services been given for as little dollar return.

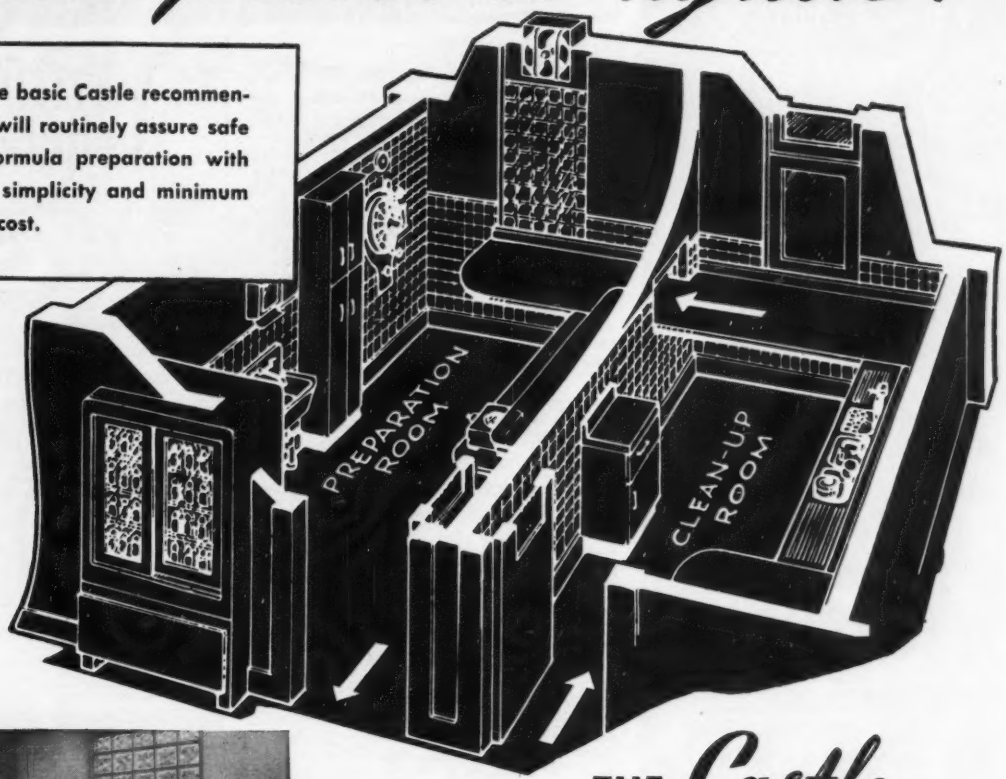
Finally, it is the role of the voluntary prepayment plan, with the cooperation of these agencies which I have just enumerated and with the continued backing of the hospital and medical profession, to provide more coverage for more people at less cost. The Maritime Hospital Service Association and all other prepayment plans should be prepared to cover all known insurable risks without limitation or exclusion, but I am personally still unconvinced that total health care falls in this field. Theoretically it may be good to attempt to give health coverage for everything patients would like to have covered but I maintain that, as a nation and as individuals, we would benefit if the smaller costs of health care were grouped together with other household and family budget items. These should be paid for from our pockets as the losses are incurred, while the larger and more catastrophic costs of health care are covered through prepayment plans.

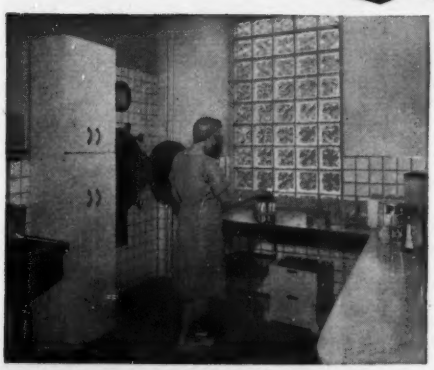
That government has a responsibility in this whole picture none will dispute; certain phases of both preventive and curative health care must necessarily be the responsibility of organized society. More and better care for those who are unable to provide for themselves must necessarily depend on the combined effort of organized society and organized medicine. We have been blessed with governments that show a willingness to assume part of this responsibility. At the same time, we must be able to demonstrate to them that we have already expanded our efforts and assumed our fair share.

To be loved is better than to be honoured.—*St. Thomas Aquinas.*

Castle proves it again!

. . . These basic Castle recommendations will routinely assure safe infant formula preparation with greatest simplicity and minimum per-unit cost.





Where practical, as in Castle's recent Genesee Hospital installation, windowed storage refrigeration facilities afford practical supervisory advantages and visitors are happily impressed.

THE *Castle* MILK FORMULA ROOM TECHNIC

● Provides for meticulous cleansing, rinsing and draining of bottles, nipples and accessories within the area designated as the receiving or clean-up section . . . time and cost are saved by terminal sterilization in the concluding process.

● In the preparation section of the Formula Laboratory, terminal heating of bottled and nippled formulas at 230°F. for 10 minutes is sufficient to produce formulas that are bacteriologically safe . . . terminal sterilization permits the use of single door autoclave construction which offers a triple saving in cost, installation and personnel. Its safety concentrates all steps in one simple process.

FACILITIES TO MEET EVERY VOLUME REQUIREMENT

Our experienced Planning Department is available to assist the hospital, the architect or hospital consultant without charge. Planning the Milk Formula Room is an important phase of our business and we welcome your invitation to suggest ways and means most economically practical.

Address your inquiry to **WILMOT CASTLE COMPANY**

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Executive Housekeeper Wanted

For modern 265-bed hospital—good location, liberal personnel policies. Experienced only need apply, stating age, education, business experience and salary desired to Box No. 934S, The Canadian Hospital, 57 Bloor St. W., Toronto.

Hospital Superintendent Wanted

For the Winchester and District Memorial Hospital. Fully modern and equipped 34-bed hospital, located in a friendly town, 32 miles south of Ottawa. Excellent meals, laundry processed. Live out. Please state age, qualifications and experience, salary expected and furnish references. Apply F. Erle Helmer, Winchester, Ontario.

Administrator Available

Canadian, aged 36, married, desires change. 100-bed institution or larger. Over 15 years' hospital experience, including fund-raising campaigns and building programs. Available in 30 to 60 days. Presently employed in 160-bed institution. Apply Box No. 923M, The Canadian Hospital, 57 Bloor St. W., Toronto, Ontario.

Dietitian Wanted

For 60-bed general hospital, preferably over 35 years of age and willing to supervise housekeeping. Apply stating qualifications to Superintendent, Strathroy General Hospital, Strathroy, Ontario.

Administrative Position Wanted

Several years' experience. Past four years comptroller of 300-bed hospital with extensive building programme. University of Toronto course in Hospital Administration successfully completed. Thorough understanding of Canadian Hospital accounting (CHAM) capable of re-organizing accounting department. Understand fully good hospital operation. Please write to Box 912P, The Canadian Hospital, 57 Bloor St. W., Toronto, Ontario.

Assistant Medical Record Librarian Wanted

For University Hospital, Edmonton, Alberta. Apply giving full particulars as to qualifications and salary required to Mr. J. L. Pedden, Personnel Officer, University of Alberta Hospital, Edmonton, Alberta.

Administrator Wanted

An administrator for 22-bed Nipigon Memorial Hospital. Duties to commence October 1st, 1955. State experience, references and salary expected. Write giving full information to: Mrs. C. F. McInnis, Secretary, Nipigon Hospital Board, Box 457, Nipigon, Ontario.

Do You Need Nurses?

Scotch, English, Irish
registered graduates, male and female
excellent registered practical nurses
registered general and mental

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504 Victoria St. Windsor, Ontario

Administrator Wanted

Applications accepted for Administrator of a 60-bed hospital. Particulars may be received from Mrs. Lilyan Wilson, Secretary, 2806-29th Road, Haney, British Columbia.

DIETITIANS REQUIRED

Qualified Dietitians for 435 bed hospital. Large Student School. New and modern Dietary Department, cafeteria and trayveyor service. Salary commensurate with qualifications and experience. Day shifts only. Liberal holidays, sick leave, pension plan and other perquisites. Excellent working conditions and quarters prevail. Transportation refundable after six months. Apply Director of Dietetics, McKellar General Hospital, Fort William, Ontario.

Notes About People

(Concluded from page 22)

tained her teaching certificate from the University of Toronto School of Nursing. She later completed her degree requirements in nursing at the McGill School for Graduate Nurses. Before enlisting in the R.C.A.M.C. in 1943, Miss MacLean spent many years at Toronto General as a head nurse, supervisor and clinical instructor. She later became supervisor of Red Cross outpost hospitals in Nova Scotia.

Hilda Bartsch

Hilda Bartsch, a graduate of the Montreal General Hospital and a distinguished member of the nursing profession, died last May. In July, 1954, Miss Bartsch was appointed executive secretary and registrar of the New Brunswick Association of Registered Nurses. Previously she had held the post of director of nursing in several New Brunswick hospitals and had also served as instructor at the Alexandra Hospital, Montreal, and at the Vancouver General Hospital in Vancouver. Miss Bartsch was president of the N.B.A.R.N. during the biennium 1948-50.

* * *

J. G. Norby to Receive A.H.A. Award of Merit

Joseph G. Norby of Milwaukee, Wisc., a hospital consultant and executive secretary of the Milwaukee County United Hospitals Fund, will receive the American Hospital Association's Award of Merit this month. Mr. Norby was a hospital administrator for many years and was president of the A.H.A. in 1949. His career in hospital administration began in 1923 at Fairview Hospital, in Minneapolis, Minn., and he has served as president and board member of the Blue Cross in both Minnesota and Wisconsin. The Award of Merit will be presented to Mr. Norby on Sept. 21 at the banquet of the A.H.A.'s 57th annual convention in Atlantic City, N.J.

• Miss Amy White, superintendent of the General and Marine Hospital, Collingwood, Ont., submitted her resignation to the hospital's board of directors recently, after four years in that position.

• Gladys Sharpe, president of the Canadian Nurses' Association and director of the nursing school at Toronto Western Hospital, and Pearl Stiver, general secretary of the CNA, Ottawa, were Canadian delegates to the International Council of Nurses board of directors' meeting held recently in Istanbul. They are also visiting the World Health Organization in Geneva and the National Council of Nurses for Great Britain and Northern Ireland.

• Mrs. Eileen Harris is the new secretary-treasurer of Pontiac Community Hospital, Shawville, P.Q. She was formerly at the Victoria Hospital in Renfrew, Ont., and is replacing Mrs. Lois Anderson, who has accepted a post at the Trafalgar-Memorial Hospital, Oakville.

• Pearl L. Morrison, superintendent of the Queen Elizabeth Hospital, Toronto, has recently returned from a trip to Europe during which she attended the International Hospital Association conference in Lucerne, Switzerland.

News Released by Hospital Supply Houses

By C.A.E.

Booklet on Standby Power Plants

The latest release of "Power Points Digest," Company publication of D. W. Onan & Sons Inc., Minneapolis, Minnesota, is devoted entirely to the application of Onan electric plants in emergency service.

How the Mercyville Sanitarium relies on a 35,000-watt Onan plant in the event of high-line power failure is described and illustrated in this two-colour, twenty-page pocket booklet.

Three Onan standby plants, totaling 110,000 watts capacity, have been installed in the St. Francis Hospital in Wichita, Kansas. How the patients and staff of the hospital are protected against the dangers of highline power interruption is told in this interesting booklet.

Copies of this special issue are available from the manufacturer. Write for Power Points Digest volume II, number I.

Parke-Davis Announces New Form of Theelin

Parke, Davis & Company has announced a new form of Theelin which is used to attain relief from menopausal symptoms.

Called Theelin R-P, the new preparation provides a means of administering Theelin in both conjugated and nonconjugated forms for immediate and prolonged estrogenic therapy benefits.

"The product is virtually free of extraneous material and thus can be expected to be of unvarying potency", the Company explained.

Designed for deep intramusclar administration, each cubic centimeter contains 2 mg. of Theelin and 1 mg. of Potassium Theelin sulfate in physiologic sodium chloride solution.

Pure, crystalline Theelin in suspension is more slowly absorbed in the muscle tissue, while Potassium Theelin sulfate is highly water-soluble and permits ready absorption.

The Company said Theelin R-P is indicated in the treatment of patients in the menopause with its accompanying symptoms such as dizziness, emotional upsets and in other conditions responsive to estrogen therapy.

Available only on prescription by physicians, Theelin R-P is supplied in 10 cc. Steri-Vials in packages of 1 and 10. It does not need refrigeration.

The recommended dosage varies in accordance with the patient's response, but usually 0.25 cc to 1 cc given one or two times weekly is adequate.

Folder on Berkel Food Service Equipment

Berkel Products Co. Limited, Toronto, have available a new folder on their complete line of Berkel equipment for the kitchen. It illustrates and describes their many types of slicers, choppers, "delicators", meat and bone cutters, scales and frozen food cases.

One of the most widely known and respected names in the equipment field is that of Berkel — a trademark which for over half a century has signified "Inside Help" of top quality — products backed by reliable, efficient service for the life of the equipment.

Garland-Blodgett Promotions

In keeping with its planned expansion program, R. A. Prowse, general manager, Garland-Blodgett Limited announces the following executive appointments:

George H. Attridge

George N. Attridge has been appointed assistant general manager and will direct internal company operations.

John D. Chesher has been appointed sales manager and will supervise the company's sales activities.

John D. Chesher

Both Mr. Attridge and Mr. Chesher have been associated with Garland-Blodgett for some time and both are well known in the commercial cooking industry.

To Build Atomic Reactor For Medical Research

The Pfizer company, leading manufacturer of antibiotics, has joined seven other U.S. Corporations in building an atomic reactor for use in research, it is announced by the com-

(Concluded on page 130)

Across the Desk

(Concluded from page 128)

pany's president, Dr. John E. McKeen.

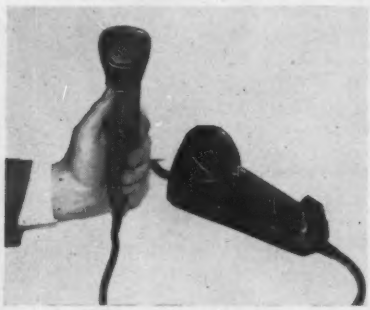
Among other things, the reactor will furnish Pfizer with short-lived radioactive isotopes for use in tracing the action of drugs in the body, Dr. McKeen said. These rare istopes have a life span of only a few days, he explained, and normally are not readily available for medical research.

Scientists know that many life-saving drugs are extremely potent agents in stopping the growth of disease-causing bacteria. They now are seeking clues to determine exactly how Terramycin and other drugs work after they enter the body.

Participating in the project, besides Pfizer and AMF Atomics, are the American Tobacco Co., Continental Can Co., Corning Glass Works, International Nickel Co., Socony Mobil Oil Co., and U.S. Rubber Co.

Dictaphone Introduces New Dictaphone Machine

A new device that puts an executive's dictation on his secretary's desk automatically was introduced recently by Dictaphone Corp. Limited. It is called the Dictaphone President with remote power control.



The President consists of a power connected to a Dictaphone Time-Master dictating machine located on the secretary's desk. The exective has full command of the dictating machine through controls located on the microphone.

With just a light movement of his thumb the dictator controls start and stop of recording, lock for continuous recording, listening, quick review playback, correction and end of letter markings. According to Dictaphone Corporation Limited, control is simple, automatic and precise leaving the dictator free to concentrate without distraction on the job at hand.

New Safe Bleach Introduced by Wyandotte

Halox, Wyandotte Chemicals' new dry bleach with "built-in" safety — just like a safety valve — is now being marketed to the laundry industry in all parts of North America. Extensive field tests of Halox show that it stops costly bleach damage to fabrics. Users report no damage even when Halox is accidentally spilled on fabric or skin.

Halox is designed to be completely safe on linens. Because of its "built-in" safety factor, users find that Halox never releases excess chlorine to lower tensile strength of fabrics. Halox releases chlorine as it is being used — a little at a time. Even accidental triple use of Halox resulted in no excessive bleach damage.

Wyandotte's new safe bleach, Halox, is sold in 25-lb. and 125-lb. polyethylene lined drums.

New Application for Lederle's Varidase

Intramuscular administration of Varidase, streptokinase-streptodornase, is now being recommended by Lederle Laboratories Division, North American Cyanamid Limited. Hitherto, the preparation has been solely for local and topical application.

Clinicals trials have shown that streptokinase component of Varidase brings about a reversal of the process of inflammation and rapidly reduces swelling associated with bruises, wounds, operations, tooth extractions and infections. By promoting more rapid healing, hospitalization in many patients is thus shortened. When infection is present, the intramuscular Varidase will aid in allowing blood-borne antibiotics and chemotherapeutic agents to reach the site of the infection. A dosage of 5,000 units of streptokinase twice daily is recommended.

Varidase now in pharmacists' stocks may be given intramuscularly. There is no product change and new package literature will include intramuscular dosage as well as local and topical dosages.

Varidase is available in vials of 25,000 (20,000 units of streptokinase) and 125,000 (100,000 units of streptokinase) units.

Appointments at C. R. Bard

Edson L. Outwin, president of C. R. Bard, Inc., has been elected chairman of the board of directors. Mr. Outwin has been associated with C. R. Bard, Inc. for 35 years.

Succeeding Mr. Outwin as president will be Harris L. Willits who has been vice president. Edson S. Outwin has been elected vice president and treasurer.

Universal Cooler's Sub-Zero Storage Cabinet

Illustrated is the new sub-zero upright storage cabinet for ice cream and frozen foods, recently introduced by Universal Cooler Company, Brant-

ford, This unit, which occupies small space, enables hospitals to store many perishable items for future use.

Driving in a dense fog, a motorist followed the tail-light ahead for a full hour, free from worry. Suddenly the red beacon ahead stopped, and the two cars collided.

"Hey, why don't you put out your hand when you're going to stop?" yelled the man behind.

Came the casual reply: "Why should I? I'm in my own garage!"

Index of Advertisers

SEPTEMBER, 1955

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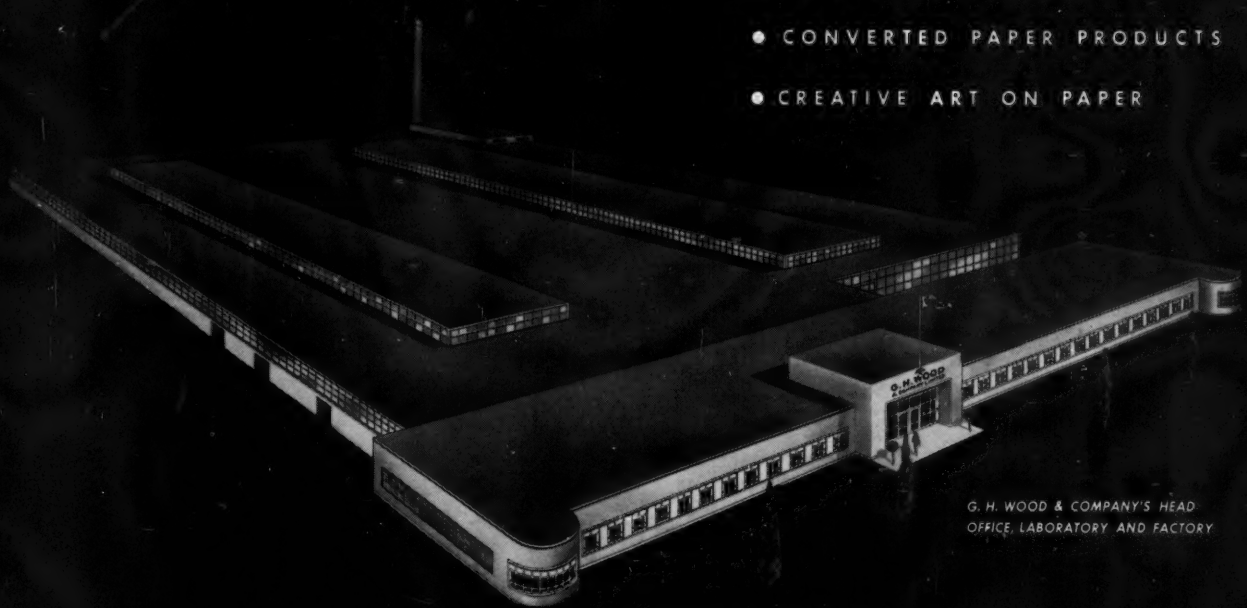

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